Healthy Ageing in Ireland: Policy, Practice and Evaluation

National Council on Ageing and Older People
An Chomhairle Náisiúnta um Aosú agus Daoine Aosta

Healthy Ageing in Ireland: Policy, Practice and Evaluation

Dr Eamon O'Shea

NUI Galway

National Council on Ageing and Older People

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National Council on Ageing and Older People
22 Clanwilliam Square
Grand Canal Quay
Dublin 2

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Foreword

As Chairperson of the National Council on Ageing and Older People, I am delighted to introduce this Report, *Healthy Ageing in Ireland: Policy, Practice and Evaluation*.

This Report makes an important contribution to the evolving discipline of health promotion with older people. It is clear that the solution to Ireland's poor life expectancy lies largely in supporting people to make healthy choices, and the development of physical and social environments supportive of ageing communities. Commitment to the implementation of *Adding Life to Years and Years to Life: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) should be on the agenda of every Government Department.

The oft-used idiom 'prevention is better than cure' applies in particular to older people. Reductions in ill-health and disability, that occur as the result of people adopting healthier lifestyles and through disease prevention, have the potential not only to improve quality of life, but also to reduce the cost of care to the State substantially.

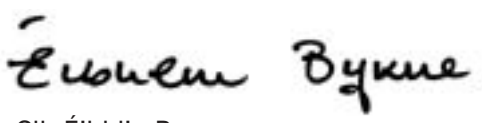
The Report is based on a national consultative process committed to hearing the voices of all sectors with a part to play in promoting health and autonomy in later life, including representatives from the housing and transport sectors, as well as statutory and voluntary providers of health and social care, and community groups.

Healthy Ageing in Ireland: Policy, Practice and Evaluation takes an important first step to building an evidence-base for 'what works' in health promotion with older people. The Healthy Ageing Database, accessible through the Council's website, and the checklist for best practice arising from this Report, should act as resources to support the further development of meaningful and innovative approaches to healthy ageing. I am also confident that the case studies presented in the Report will inform and inspire the reader in relation to elements of best practice in programmes promoting health and autonomy in later life.

On behalf of the Council I would like to thank all those representatives who engaged with the consultative process conducted as part of this research. I would like to thank the author, Dr Eamon O'Shea, and researcher, Ms Edel Murphy, for

preparing the Healthy Ageing Database and this valuable study on the findings from the exercise. I would also like to thank the members of the Healthy Ageing Consultative Committee who advised on progress of the research and oversaw the preparation of the report: Dr Michael Loftus (Chairperson); Mr Peter Sands; Ms Mary Nally; Dr Sheila MacEvilly; Ms Mary McDermott; Ms Mary O'Neill; Mr Jim Cousins; Dr John Gibbon; Ms Angela King; Dr Shelagh Wright; Mr Shay McGovern; Dr Margaret Hodgins; Ms Ann Leahy; and Ms Martina Queally.

Finally the Council would like to thank its Director, Mr Bob Carroll, its Healthy Ageing Programme Advisor, Dr Helen McAvoy, and Healthy Ageing Programme Project Officers Ms Dervilla Keegan and Ms Jane England. Thanks are also extended to Ms Gabrielle Jacob, Resources and Publications Officer, for meticulously preparing the Report for publication and to the Council's administrative staff for their ongoing support.



Cllr Éibhlin Byrne
Chairperson

Author's Acknowledgements

Many people contributed to the production of this report.

We met many people during the regional seminars and I would like to thank these people for their time and input to the project, including the following:

- representatives from older peoples' organisations – active retirement associations and other community-based organisations of older people, national organisations representing and working on behalf of older people, and clients from health board and voluntary day-care centres

- representatives from the health boards – people working in long-stay care settings, in acute hospitals, in day-care and in day hospitals; administrators, particularly from services for older people and health promotion; people working with carers; specialists working in the areas of suicide prevention, mental health and psychiatry of old age, nutrition and diet, occupational therapy, physiotherapy, speech and language therapy, continence promotion, falls prevention and diabetes, public health nurses, home-help organisers and other community-based personnel, and geriatricians

- representatives from many different parts of the voluntary sector – from voluntary housing organisations, from community development groups, from day care centres and long-stay care settings, from social economy projects, from community-based organisations concerned with transport, with security, with social interaction, with energy issues, with maintenance of houses, with the provision of respite care, with the provision of home-helps, from women's groups, disability groups and support groups for specific illnesses; from organisations providing support to specific groups, for example, carers and people with dementia and other mental illnesses

- representatives from statutory organisations – local authority housing personnel, librarians from public libraries, VEC adult education officers and representatives from adult education and other departments in third-level institutions with an interest in older people's affairs, county council arts officers and representatives of other arts organisations, and representatives from the Garda Síochána

- representatives of private nursing homes.

I would also like to thank the coordinators in each of the health boards, who worked with us to organise the regional seminars, namely: Mary McDermott, WHB; Ann Coyle, NEHB; Mo Flynn, (with Janet Convery, Dr Shelagh Wright and Jackie Ebbs), ERHA; Hilary Scanlon, SHB; Carmel Taheny, NWHB; Una Doherty, SEHB; Geraldine Hanna, Paschal Moynihan and Alice Varley MWHB; and Margaret Feeney, MHB.

In addition, I would like to thank the organisations that contributed to the development of Chapter Six, the case studies on healthy ageing.

Finally, I would like to thank Dr Helen McAvoy for her detailed feedback on each of the drafts of this report and her constant support during this project, as well as the project officers working on the Healthy Ageing Programme, Ms Dervilla Keegan and Ms Jane England. Lastly, I would like the members of the Consultative Committee set up by the Council to steer this project through to completion.

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Introduction

The National Council on Ageing and Older People (NCAOP) is pleased to present this report, which provides a comprehensive overview of current practice in the promotion of healthy ageing in Ireland. The Council considers 'healthy ageing' to be a positive concept relating to personal development and the exercise of personal choice. Healthy ageing therefore includes activities that influence social and environmental changes, which promote health, well-being and activities that prevent illness.

The Council remains deeply concerned that life expectancy at age 65 in Ireland still lags considerably behind the EU average and that Ireland's older people currently experience a greater degree of ill-health and disability than most other European countries. It is Council's belief that success in the healthy ageing of our population will be achieved not solely through the adequate provision of health services, it also requires ongoing commitment to a multi-annual programme of health promotion. The Council is therefore keen to ensure that the goals and action plans set out in *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) continue to be implemented and monitored.

The Council welcomes the Report's analysis of healthy ageing initiatives originating from a wide range of sectors including health promotion, health services, local authorities, statutory bodies, cooperative and voluntary groups, and community groups such as active retirement groups. The findings from a national consultation process, which facilitated discussion on an unprecedented level among the diverse range of sectors with a role in promoting healthy ageing, have been presented in the Report. The views of key stakeholders in projects and services that promote health and well-being in later life were elicited through regional seminars in each

health board region. Information on current practice and details on specific projects were elicited from a postal survey subsequent to the seminars. The Council invites all parties with an interest in developing healthy ageing initiatives to search the Healthy Ageing Database arising from this process at www.ncaop.ie.

The Council considers this Report to be timely, being published at a time of reform in the Irish health services heralded by the National Health Strategy (DoHC, 2001a). This reform promises to develop the disease prevention, rehabilitation and personal social services capacities of community-based care services. This will complement the existing diagnosis and treatment focus within primary care (DoHC, 2001b). Indeed, this Report supports many of the recommendations made in the Primary Care Strategy and will act as a resource for the development of good practice in service development and project work with older people as part of the new primary care model.

The Report also makes an important contribution towards building on the diverse skills and experience of a range of sectors working in the field of healthy ageing. The Council hopes that its findings will contribute to the development of the capacity of all sectors to work in partnership towards securing a healthier and more enjoyable old age for the senior citizens of today and the future.

Policy

1. The Council understands that increased accountability is central to the Health Service Reform Programme currently underway (DoHC, 2003). **It recommends that the reformed health structures make provision for monitoring progress with the implementation of *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) on an annual basis, in line with the statutory obligation on health boards 'to develop and implement health promotion programmes appropriate to local needs' (*Health Amendment Act*, No. 32, 1996).**

2. The Council is struck by the negative influence of ageism on projects and services promoting healthy ageing identified in this Report. It indicates that misconceptions and negative attitudes to older people perpetuate the inadequate allocation of service resources to older people and leads to an underestimation of the benefits of healthy ageing projects and services on the

part of policy-makers (Table 4.8). **The Council therefore recommends that ongoing monitoring and resourcing of equality measures for older people, as detailed in *Implementing Equality for Older People* (Equality Authority, 2001) would strengthen the development of healthy ageing in Ireland.** It believes that the introduction of age-sensitive Health Impact Assessment as part of the public policy development process would further strengthen the development of policies supportive of healthy ageing. Such an approach would be in keeping with the commitments made regarding health impact assessments in the National Health Strategy (DoHC, 2001a)[1]. In relation to existing policy, policy review by interdisciplinary scrutiny panels might be considered by health boards following the example of Standard One of the UK National Service Framework for Older People (DoH, 2001). Such a panel would review existing upper age limits including clinical evidence and the views of older people/carers in relation to issues, such as current upper age limits for breast-screening, and make recommendations to the boards.

3. The Report indicates that funding mechanisms for the development of healthy ageing are *ad hoc*, fragmented and arbitrary. Although as much as 95 per cent of healthcare spending comprises medical care and biomedical research, lifestyle behaviours and environment are responsible for more than 70 per cent of avoidable mortality (Institute of Medicine Committee on Assuring the Health of the Public in the 21st Century, 2002). In the Irish context, an inadequate percentage of health services funding (0.19 per cent) is being spent on health promotion in Ireland (DOHC, 1999). It is therefore unsurprising that the development of *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998) has been identified as good investment in the *Value for Money Audit of the Irish Health System* (Deloitte and Touche, 2001). **The Council supports the recommendation made in this Report that the Department of Health and Children allocate a national annual fund of €5 million to support and promote the development of national healthy ageing initiatives. This fund would include a budget to be allocated for large-scale projects on the basis of a competitive tendering process operated by the Healthy Ageing Programme and assessed according to the guidelines for best practice proposed in this Report. The Council recommends that ten per cent of this budget be allocated specifically to support the evaluation of pilot projects.**

4. The Report indicates that development of proactive, preventive and innovative approaches to healthy ageing is greatly hindered by inadequate resourcing of the community care system. Patchy provision of community services and the provision of such services with a sole focus on basic care mean that the vast

1 Information to support policy-makers in undertaking health impact assessment can be sourced in *Health Impact Assessment: A Practical Guidance Manual* (Institute of Public Health In Ireland, 2003).

potential for these services to promote healthy ageing through health education and partnership working (e.g. community dieticians and meals on wheels) remains largely untapped. **The Council wishes to reiterate the recommendation that home and community services for older people be established on a statutory basis (Garavan *et al.,* 2001; DoH, 1988). It recommends that this long overdue commitment to develop the appropriate legislation be implemented as part of the response to Recommendation 1.1 of the *Audit of Structures and Functions of the Health Service* (DoHC, 2003).**

5. The Council recognises that health is an asset built up over the life-course, and adopting healthy behaviours early in life increases the potential for a long and healthy old age. **Therefore it recommends that assigning ongoing investment to the implementation of the recommendations made in the following national health promoting strategies and programmes will ultimately be of benefit to future generations of older people:**
   - *Strategic Task Force on Alcohol* (DoHC, 2002)
   - *Towards a Tobacco Free Society* (DoHC, 2000a)
   - *Building Healthier Hearts* (DoHC, 1999)
   - *Health Promotion in the Workplace: Healthy Bodies – Healthy Work* (DoHC, 1998a)
   - *Report of the National Task Force on Suicide* (DoHC, 1998b).

6. The Council is disappointed to note the lack of implementation of the *Recommendations for a National Food and Nutrition Policy for Older People* (Food Safety Authority, 2000) despite the commitment to support the implementation of these recommendations made in the *National Health Promotion Strategy 2000-2005* (DoHC, 2000). **The Council endorses Recommendations 5.1 and 5.2 of *Recommendations for a National Food and Nutrition Policy for Older People,* which states that the Department of Health and Children should oversee the implementation of the policy at national level and that appropriate ring-fenced resources should be allocated (Food Safety Authority, 2000).** It considers that a review of the implementation of these recommendations be conducted in 2005 in conjunction with the Food Safety Authority.

7. The Council is concerned at the inhibiting effect of the costs of public liability insurance on the development of community-based initiatives promoting healthy ageing. **It recommends that a national support structure be put in place to review and reduce the costs of public liability insurance for community groups engaged in health promoting activities. Council considers that the development of group insurance schemes such as the Group Insurance Scheme for Voluntary Social Services Organisations (Comhairle, 2002) would assist in reducing the cost of public liability insurance.**

Needs Assessment

8. The Council recommends that the health promotion needs and preferences of older people can only be met through community- and service-based healthy ageing initiatives that are based on holistic needs assessment with older people themselves. It welcomes the commitment made in the Primary Care Strategy (DoHC, 2002b) for individual health boards to prepare needs assessments for primary care teams. **The Council recommends that each health board and local authority allocate resources for ongoing needs assessment in relation to health and health promotion needs of older people, and that needs assessment be conducted in a cost-effective manner through partnership working with community groups and community-based services.** Assessment of needs in community and domiciliary health and social service settings, and assessment of eligibility for grants and subventions should also form part of a single assessment process (Delaney *et al.,* 2001; NCAOP, 2003).

9. The Report indicates that most healthy ageing projects do not originate from comprehensive needs assessment data collected by statutory agencies. **The Council recommends that local authorities conduct Housing Needs Assessment for their older citizens and plan for projected increases in housing demand for older people.** The validity of the current system of Housing Needs Assessment for assessing the needs of older people should be examined (see recommendation 18).

Funding

10. The Report indicates that sustainability is considered a key element of best practice and that the sustainability of health promotion projects and services for older people is threatened by the inability to secure ring-fenced multi-annual funding. The Council recognises that successful healthy ageing initiatives depend on consultation and partnership working, which are time-consuming, and that the effects of many healthy ageing initiatives may not be apparent for several years. **It therefore recommends that multi-annual funding is required for healthy ageing initiatives and that sustainability will be further facilitated by the provision of protected staff time and designated lead persons.**

11. The diversity of projects in the Healthy Ageing Database indicates that funding resources for healthy ageing can be derived from a variety of sources including public agencies, European Union funds and trusts, and foundations. The Council recommends that organisations seeking funding for health promoting projects and services explore these options.[2]

Networking, Consultation and Partnership

12. The Council considers the use of regional seminars, as organised as part of the research process for this study, as most successful in facilitating inter-sectoral discussion and assessing issues in practice. The Report clearly states that consultation with older people is the most essential element of best practice. **The Council strongly recommends that all sectors, and health boards and local authorities in particular, develop their consultative processes with older people in the planning stages of healthy ageing initiatives and strategies.** The Council considers that health boards (or their equivalent under the reformed health services) could replicate the inter-sectoral format of these seminars to allow for ongoing review and support of the development of the practice of healthy ageing.

13. The case studies presented in this Report demonstrate successful examples of partnership working between a range of voluntary and statutory bodies. However, the consensus at the regional seminars was that such partnership models are generally lacking, an issue previously examined in Council research (Mulvihill, 1993). **The Council reiterates the recommendation that the establishment of local intermediary bodies in each community care area would contribute to the success of partnerships, by developing the voluntary sector in liaison with the health board and local authorities as appropriate.** The Council also supports the designation of Voluntary Activity Units in relevant Government Departments to facilitate dialogue between the statutory and voluntary sectors (Department of Social and Community Affairs, 2000).

14. The Council is concerned that the Report uncovered a lack of integration and communications within health board regions in terms of the healthy ageing initiatives operated by different sectors. It is also concerned that the lack of communication reported between health board regions leads to duplication of effort, poor coordination and wasted resources. **The Council recommends that parties planning healthy ageing initiatives familiarise themselves with existing projects and initiatives using the Healthy Ageing Database (www.ncaop.ie).**

2 Information to support organisations seeking funding can be sourced in *Irish Fund-raising Handbook, Directory and Guide to Fund-raising for Non-Profit Work in the Republic of Ireland* (Café Publications/ Clann Credo, 2003).

Capacity-Building to Promote Healthy Ageing

15. The Report demonstrates that the promotion of healthy ageing is based in community settings, with projects and services occurring for the most part through the work of community groups or as a component of community-based services, in particular day services. Health promotion has been identified as a primary objective for all types of day service in Ireland (Haslett, 2003). **The Council recommends that health boards proactively develop the health promoting capacity of day services through appropriate resourcing and organisational development.** It can be inferred from the Report that such capacity building would be facilitated by
    - the training of day service personnel in health promoting skills, such as effective health education
    - the allocation of ring-fenced health promoting budgets
    - the allocation of protected staff time to preventive and health promoting activities.

16. The report recognises that Active Retirement Associations (ARAs) represent a powerful and accessible vehicle for healthy ageing at community level. **The Council advises that capacity-building of ARAs would be of benefit in promoting the health of older people.** It recommends that this capacity-building be supported through organisational development and the provision of training (e.g. the Quality Counts Initiative, Age Concern Northern Ireland) and inter-sectoral working between ARAs and health promotion departments.

17. The Report indicates relatively few healthy ageing initiatives in a general practice setting. Council research has consistently recognised the pivotal role of general practitioners (GPs) in the preventative care of older people (Garavan *et al.,* 2001). **The Council recommends that health promotion departments become more proactive in relation to partnership working with GPs and Public Health Nurses (PHNs) in regard to healthy ageing[3]. It further recommends that the issue of screening policy for older people be considered in conjunction with the Primary Care Task Force and Steering Group, building on the research conducted by the Irish College of General Practitioners as part of the 1993 Irish National Care of the Elderly Study (Dobbs and Prosser, 1997; Dobbs, Prosser *et al.,* 1999).**

3 For further information in this regard, see *Health Promotion With Older People: Adding Years to Life – Adding Life to Years. Ideas for Primary Health Care Teams.* (Ageing Well UK, 1994).

18. The Report indicates that housing appropriate to the needs and preferences of older people is lacking and is a significant obstacle to healthy ageing. The key issues raised by stakeholders were:
    - the unacceptable standards currently encountered in older people's housing – a view consistent with the research finding that older people are more likely to experience housing deprivation (Layte *et al.,* 1999)
    - inefficiency and inequity experienced in accessing opportunities for housing improvements and adaptations (NCAOP, 2003)
    - the lack of options and information on choices in relation to transitional housing options for older people requiring assisted living but not wishing to enter residential care
    - the lack of strategic planning by local authorities in relation to in catering for current and future generations of older people (e.g. quotas of life-time adaptable housing etc.).

    The Council recommends that the Department of the Environment, Heritage and Local Government develop a comprehensive ten-year strategic plan to respond to future housing needs and preferences of older people. It further recommends that a national survey on the housing conditions of older persons be conducted, as advocated in *The Years Ahead: A Policy for the Elderly* (DoH, 1988) and *The Impact of Social and Economic Policies on Older People in Ireland* (O'Shea, 1993).

19. The Report also identified relatively few projects in a workplace setting. **The Council recommends that healthy ageing initiatives be fostered in a workplace setting on the agenda of health and safety officers and occupational health professionals, as well as workplace health coordinators and health promotion officers with a workplace remit. The Council considers that the development and evaluation of meaningful pre-retirement courses should be considered as a core responsibility of all employers.**

Priority Groups of Older People

20. The Report corroborates earlier findings that gender plays an important role in defining older people's preferences in availing of opportunities for healthy ageing (Haslett, 2003; UN, 2002). The Council expresses particular concern in relation to the life expectancy of Irish men and women at age 65. In regard to women, the Report indicated a widening of the health disadvantage compared to all other European older women. **The Council recommends that older women be increasingly prioritised in policy and strategic planning on**

statutory and voluntary bodies working on the women's health agenda. Previous Council research would indicate that targeted intervention in preserving the income of older women might be of benefit (Layte *et al.,* 1999). The Council recommends that interventions to reduce rising female smoking rates would have a substantial impact on female life expectancy figures in the long-term.

The lesser involvement of men in healthy ageing initiatives has also been reported in relation to attendance at day services, identified in this Report as a key setting for health promotion (Haslett, 2003). **The Council recommends that consultation with older men is required to understand their preferences in terms of group or individual approaches to healthy ageing. It further recommends that Health Promotion Officers with a remit for men's health devise specific programmes and evaluation processes according to the needs and preferences of older men.**

21. The Report indicates that relatively few existing healthy ageing initiatives have a specific focus on lower-income groups, although older people on a lower income were seen as a future priority group by many stakeholders. **The Council recommends that older people on lower incomes be given priority by all sectors working in healthy ageing. It also recommends that specific resources be allocated for low-income older people within each health promotion department and local authority.** An example of existing practice in this area has been the establishment of a team of low income community dieticians by health board community dietician managers.

Evaluation

Evaluating Progress with the Health Promotion Strategy for Older People

22. The Council recognises the challenges, identified in the Report, in monitoring progress towards the goals and action plans set within the broad agenda of *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998). It agrees that progress can be most effectively measured against specific, measurable and time-scheduled objectives, against which a benchmarking process can then be devised. **The Council proposes that it would monitor both life expectancy and healthy life expectancy in later life, as presented in this**

Report. In this way, progress towards the goals of the Healthy Ageing Programme can be assessed.

23. **The Council proposes that progress in achieving the specific objectives set in relation to reductions in the mortality figures for cardiovascular disease, cancer, smoking and accidents be assessed as part of the Healthy Ageing Programme in 2005, as indicated in *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998).**

24. The Council considers that meaningful monitoring of the Healthy Ageing Programme is threatened by information deficits in relation to a variety of issues specified in *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998). National prevalence figures for the following would assist in the goal setting and monitoring:
    - visual and hearing impairment
    - dental health
    - mental health
    - lifestyle (smoking, alcohol, diet and physical activity)
    - housing conditions
    - income
    - transport accessibility.

    The Council has previously recognised the poverty of incidence data in relation to mental disorders in later life and recommended that person-centred information systems be developed to routinely collate the activities of all health and social care services (Keogh and Roche, 1996). **It advises that these recommendations be considered in the reformed health structures, which propose to put in place robust information gathering and analysis capability in conjunction with the National Health Information Strategy and the Health Information Quality Authority (DoHC, 2003).**

Evaluation of Individual Projects

25. The Report reveals the complexity implicit in the evaluation of healthy ageing initiatives and that evaluation processes in health promotion with older people are at an early stage of development. The Council acknowledges that a culture of evaluation should be developed in health promotion with older people, and recommends that evaluation be considered integral to the planning of healthy ageing interventions by all sectors. **The Council also recommends that health promotion departments support the evaluation of initiatives operated in the voluntary sector in an advisory capacity.**

26. The Council welcomes the considerations of cost-efficiency in the Report, as it believes that healthy ageing is excellent value for money, with healthy older people requiring fewer acute services by virtue of decreases in disability rates and diminished needs for care (UN, 2002). **It recommends that considerations of cost-efficiency are important so that healthy ageing initiatives can compete for scarce resources in relevant local, regional and national budgets.**

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Executive Summary

Executive Summary

Background to the Study

Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People (Brenner and Shelley, 1998) marked the formal beginning of the Healthy Ageing Programme in Ireland. The objectives of the Strategy are:

- to improve life expectancy at age 65 and beyond
- to improve the health status of people aged 65 and beyond
- to improve the lives and autonomy of older people who are already affected by illness and impairment.

The Strategy recognises that the promotion of health for older people is not solely a matter for the Department of Health and Children, but for all Departments and organisations whose policies and actions may potentially have an impact on the health of older people. The implementation of the Strategy requires the development of an information and support network for promoting the health, welfare and autonomy of older people, as well as the identification and promotion of models of good practice for healthy ageing. This Report is part of the process of extending and developing a knowledge-base on healthy ageing activities in Ireland.

Notwithstanding the evolution of policy-making in this field, the position of older people in Ireland relative to other countries as measured by life expectancy and healthy life expectancy at older ages has deteriorated in the past decade. Ireland remains at the bottom of the life expectancy table in Europe and the relative standing of older people has got worse not better in recent years. This Report provides some insight on what should be done to improve the position of older people in Ireland in the field of healthy ageing in the coming decades.

Objectives of the Project

The objectives of the project are:

- to generate a comprehensive database of healthy ageing activities in Ireland
- to examine the current situation of health promotion initiatives for older people in Ireland
- to provide criteria for best practice in the planning, operation and development of healthy ageing projects
- to provide criteria for the evaluation of healthy ageing projects.

Information on healthy ageing has heretofore been fragmented and the development of a Healthy Ageing Database will improve existing knowledge, as well as providing a facility for groups to network and identify areas in need of investment and development. The identification of models of best practice is the logical extension of the data generation exercise and will be an important aspect of future resource allocation in this field. Similarly, providing an evaluation framework will allow worthwhile projects to be more readily identified and rewarded.

Methods

The Report is based on extensive consultation with stakeholders in the field of healthy ageing in Ireland and adheres to a participative model of research in keeping with best practice in health promotion investigation. Eight regional seminars on healthy ageing were held over a period of six months in each of the health board regions. The purpose of the regional seminars was:

- to bring together representatives of healthy ageing projects from health boards, voluntary groups, community groups, local authorities and older people themselves
- to generate discussion that would inform national best practice in the field of healthy ageing for older people

- to obtain a comprehensive list of contact persons and addresses for all healthy ageing projects in that region
- to facilitate communication and networking in the field of healthy ageing.

Participants at the seminars in each region were asked to consider four major issues in relation to healthy ageing activities as follows:

- current priorities
- future priorities
- issues in the planning, development and operation of healthy ageing projects
- best practice.

The philosophy of the project was to involve all stakeholders in setting priorities for healthy ageing and in establishing criteria for best practice in the field. There was extensive discussion on these issues within seminar groups. Verbal feedback was gathered from groups during the seminar and discussed. Written feedback was also collected from groups and some individuals at the end of the seminars.

Lists of contacts for healthy ageing projects were generated at the seminars and subsequently through further communication with participants. Overall, while the contact details provided through the seminars were invaluable, fewer contacts were generated than had been hoped. This reflected the information deficit and fragmentation of information with respect to healthy ageing activities both within and across health board regions. Health board personnel provided additional contact details for health-board run activities and some non-health board activities. Voluntary and community groups provided information about their own work in their particular area.

A postal questionnaire was sent to all potential projects identified during the consultation stage of the research. The issues addressed in the questionnaire were similar to those considered in the seminars. Overall, 1,400 questionnaires were sent to potential projects. Those who did respond to the questionnaire did so almost immediately and most of the returns occurred within the first month of the data collection process. There was ongoing and selective follow-up of known projects that did not respond to the initial questionnaire.

Key Findings from the Regional Seminars

One of the recurring themes raised at the seminars was the prevalence of ageist attitudes in Ireland. People felt that multisectoral and inter-disciplinary progress in healthy ageing was being impeded by the presence of an ageist culture in Irish society. The age of an individual is too often used as a proxy for determining a person's capability, flexibility, adaptability and health, all of which are assumed to decline as a person approaches old age. The view from the seminars was that ageism can and should be challenged, and participants advocated action to combat it at national, regional and local levels.

Participants were also aware of the multidimensional nature of healthy ageing and emphasis was placed on the need for the development of an integrated holistic model of ageing. Although many health-related issues were raised during the seminars and important points were made in respect of access to community care and appropriate residential care, people were conscious of the need to look beyond bio-medical interpretations of well-being. The importance for successful healthy ageing of inter-generational relationships and solidarity between the generations was highlighted during the seminars. Housing and transport were also seen as important elements of healthy ageing for older people.

In terms of the development of healthy ageing projects, participants were particularly concerned about the lack of funding to support innovation and best practice in the formulation and implementation of projects. Concern was expressed that many local communities do not get beyond the general recognition of problems and, even when they do, their response is often isolated and narrowly focused with poor links to outside communities and agencies. Many of the integration problems stem from the fact that healthy ageing tends to cross traditional functional and administrative boundaries, and is not comprehensively dealt with by any one statutory body. Community groups trying to embrace a holistic model have to deal with a myriad of organisations, and the process of generating support and resources for healthy ageing projects is enormously time-consuming. These difficulties are magnified by the absence of partnership models for public, private and voluntary cooperation in the field of healthy ageing.

Consultation with older people was considered by seminar participants to be the most essential element of best practice in healthy ageing. The view was strongly held that older people should be involved in a project from the planning stage through to the evaluation of outcomes. There was criticism that the structures necessary to allow meaningful consultation were not always in place. Continuity

and sustainability were also mentioned as central to best practice and were linked to both funding and information-sharing at local, regional and national levels. Participants wanted greater information on good and bad practice in the field of healthy ageing through formal evaluation procedures. Currently, good practice is not being replicated because people do not know of its existence or constituent parts. There was also support for the implementation of common standards with respect to the provision of health board services for older people, which people saw as varying widely across the country.

Key Findings from the Survey

Almost half of all healthy ageing projects that responded to the questionnaire are concerned with the social environment of older people. The social environment category includes such areas as social interaction, public attitudes, retirement issues and income support. Just over twenty per cent of projects occur in active retirement groups or sport/recreation club settings. A further sixteen per cent occur in a day care/day centre setting. Ten per cent of projects occur in an older person's own home. There appears to be a distinct lack of projects in general practice and community care settings.

The majority of projects develop from the bottom up, sometimes with little support from official sources. Seventy per cent of projects came about because of an initiative taken by the organisation providing the service. Generally, projects are evenly divided between those where a needs analysis had been conducted and those where no such analysis took place. Projects are usually small in scale, with two thirds having less than fifty participants per week and one third having less than twenty. The ratio of female participants to male participants in healthy ageing projects is three to one. Projects are mainly staffed by part-time voluntary workers.

With regard to future development and expansion of projects, inadequate funding was regarded by respondents (twenty per cent) as the principal obstacle. This was followed by ageist attitudes (thirteen per cent), the lack of interest in healthy ageing among policy-makers (twelve per cent) and the absence of an integrated holistic approach to healthy ageing and well-being (twelve per cent).

Increased funding for social interaction and integration and the promotion of better attitudes to old age and society, were regarded as priority areas for the future by survey respondents, with sixteen and twelve per cent respectively of respondents highlighting these two areas. Mental health promotion also scored highly as did stroke prevention. Personal and creative development for older people was also seen as important.

Older people living alone were regarded as a priority group by survey respondents, with one third suggesting that projects in this category should receive additional funding if such funding were to become available. Homeless older people, older people in deprived economic circumstances and rural older people were also considered deserving groups, with thirty-five per cent of respondents indicating that they should receive priority in the future.

Healthy Ageing: The Future

Ageism has been identified as a critical issue for older people. Age proofing should be applied to all areas of public policy-making, particularly the areas of health and social care, employment and education. More resources should be directed towards changing attitudes to ageing in society beginning with the launch of a high profile national advertising campaign designed to challenge existing stereotypes. Training in age awareness and the development of skills to combat ageism should be routinely provided in the public service and in the work-place generally, building on recent policy initiatives in this area. Entitlements in respect of community-based social care services should be legislatively-based to ensure services are available to older people who need them. For example, legislation is required to provide equal and easy access for older people to all primary care services.

A designated and protected Healthy Ageing Fund should be established by the Department of Health and Children to encourage innovation and experimentation in respect of healthy ageing projects. There should be a competitive tendering process for large-scale projects and five annual large awards made under each of the five headings of the Ottawa Charter. The annual fund should be in the region of €5 million and could also be used to support small-scale projects. There should be seed capital available for smaller projects and a separate application process for this funding. The Fund should be administered by the NCAOP's Healthy Ageing Programme. Evaluation should also be central to the allocation of scarce resources in the healthy ageing field and the NCAOP should have a role in providing advice and support with the design of evaluations for agencies that need support in this area.

Housing is a key element in keeping older people well and living in the community. Good housing enables older people to continue living independently and to maintain life-time social contacts and networks. There is work to be done on improving the housing stock of older people and in making housing more

accessible and barrier-free, so that older people can remain in their own homes even if they become dependent.

There is also a need to provide, through public/private/voluntary partnerships, sheltered accommodation in local settings, which is appropriately designed, monitored and maintained, as a step-up alternative to older people moving from home directly into residential care. Older people and their representatives should be an important part of the partnership process in developing appropriate housing. Community care services should be linked to sheltered housing provision with the emphasis on health promotion and healthy ageing. Some older people in sheltered accommodation will eventually require nursing home care and careful planning should allow for seamless transition between community and residential care living for these people.

Capacity-building for voluntary and active retirement groups at community level is also necessary to the fulfilment of healthy ageing goals. The Healthy Ageing Programme can play a major role in this regard by acting as a valuable resource to support voluntary groups in achieving best practice in the operation of healthy ageing projects. Capacity-building could take the form of supporting training workshops in planning, running and evaluating healthy ageing projects and supporting groups in an advisory capacity. Active retirement groups provide a real opportunity for mutual self-help, which is in itself empowering. They require greater support, however, through seed funding for innovative healthy ageing projects and training in the area of participation and empowerment.

Older people should be placed at the centre of decision-making both in the community and in residential care. The hypothetical case studies used to illustrate best practice in healthy ageing in this Report should form the basis of two pilot projects designed to explore the implications of providing greater autonomy and choice to older people living at home and in residential care. Funding for community care services needs to be enhanced through the provision of person-centred community-based subventions for vulnerable older people. These subventions will allow older people more choice and facilitate the development of community-based services, some of which might be provided through an expanded social economy system.

Social isolation, anxiety and depression are important contributory factors to frailty and loss of function in later life. Mental health promotion can play a key role in healthy ageing for older people. Specific targeting of vulnerable older people through screening and subsequent social interaction and networking projects can

reduce isolation. Community activities, accessible transport and life-long learning courses can also help alleviate isolation and anxiety. Local initiatives, based on local knowledge, may be important in developing the social capital necessary to promote better mental health in local communities. For example, providing ongoing and appropriate support during bereavement can have a significant impact on healthy ageing.

The participation of older people in creative activities is also important. It is encouraging to find many healthy ageing projects for older people in the area of the Arts and that public libraries are important hosts of many creative activities for older people. The exposure of older people to creative and artistic activities should become part of mainstream healthy ageing policy with increased funding for such activities coming from both the health boards and the local authorities. People in residential care and in nursing homes should be given the opportunity to develop their creative potential. Where this has happened, outcomes and quality of life have improved for residents and staff.

Healthy ageing should form an integral part of the Primary Care Strategy. Pilot projects in the form of healthy ageing clinics should be supported in general practice. Specialist advice could be available to older people at these clinics, provided either by a GP or a specialist nurse. These clinics could be used for screening and lifestyle advice and for the referral of older people to specialist secondary care outpatients if appropriate.

Best Practice

Criteria for making decisions on best practice in healthy ageing are developed in this Report. The elements comprising best practice are based on the discussions in the regional seminars and the responses from the postal questionnaire. The critical elements of best practice in healthy ageing are as follows:

- needs assessment undertaken prior to the commencement of the project
- consultation with older people throughout the duration of the project
- participation of older people in the planning and operation of the project

- empowerment of older people through the operation of the project
- partnership models that encourage cooperation and integration of all interested parties
- adequate funding and operating structures to ensure the sustainability of the project over the longer-term
- evaluation criteria built into the project from the beginning
- equity criteria to ensure the maximum participation of all categories of older people
- information generation and information-sharing as essential elements of the project.

Chapter One
Introduction

Chapter One

Introduction

1.1 Purpose of the Project

This chapter provides the context for this Report, which seeks to examine and explore healthy ageing policy and practice in Ireland. The objectives of the Healthy Ageing Programme as stated in *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) are:

- to improve life expectancy at age 65 and beyond
- to improve the health status of people aged 65 and beyond
- to improve the lives and autonomy of older people who are already affected by illness and impairment.

It is difficult to envisage these objectives being achieved without significantly improved knowledge of existing activities in healthy ageing and some discussion of best practice in this expanding and diverse field. The purpose of this Report is to chronicle the development of a comprehensive Healthy Ageing Database for Ireland and provide some insight into best practice in the field of healthy ageing. To date, information on healthy ageing has been fragmented and the development of this Database will improve existing knowledge, as well as providing a facility for groups to network and identifying areas in need of development. The Report is based on extensive consultation with stakeholders in the field of healthy ageing in Ireland and adheres to a participative model of research in keeping with best practice in health promotion investigation.

1.2 Defining Healthy Ageing

Successful ageing is difficult to define (Glass, 2003), and a number of terms are used in the literature (often it seems interchangeably) including 'productive ageing', 'active ageing' and 'healthy ageing'. The term 'productive ageing' came to the fore in the early 1990's and was generally used in relation to promoting economic contributions by older people through participation in the labour market. Policies concerned with productive ageing dealt mainly with ways to increase the participation of older workers in the labour force, such as the removal of age discrimination in the workplace, and training and re-training programmes (Davey, 2002).

The term 'active ageing' gained prominence during the 1999 United Nations Year of Older People and was subsequently used by the WHO, who currently define active ageing as 'the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age' (WHO, 2002). In 1999 the European Commission held a conference on active ageing and outlined its key elements which included:

- working longer
- retiring later
- being active after retirement
- engaging in health sustaining activities
- being as self-reliant and involved as possible.

The term 'healthy ageing' is used throughout this Report, as it forms part of the Healthy Ageing Programme developed by the NCAOP. While healthy ageing implies a focus on the maintenance of health, often through lifestyle choices and preventive measures (Davey, 2002), it is used here in a broader context. Healthy ageing, as used in this Report, is concerned with increasing the quantity and quality of life of older people. While health is an important determinant of quality of life of older people, it is by no means the only factor that is important. All factors that potentially contribute to the quality of life of older people (including health, income, security, social relations, participation, empowerment etc.) must be considered and addressed. Healthy ageing refers to the capacity of older people to function across many domains, including the cognitive, medical, social and

emotional. A multisectoral approach that deals with all organisations, whether they are governmental or non-governmental, is, therefore, required in order to achieve healthy ageing.

Healthy and active ageing is a global movement supported by the WHO. In its contribution to the Second World Assembly on Ageing in 2002, the WHO recognised that when health, labour market, employment, education and social policies support healthy ageing, there will be:

- fewer premature deaths in the highly productive stages of life
- fewer disabilities associated with chronic diseases in older age
- more people enjoying a positive quality of life as they grow older
- more people actively participating as they age in social, cultural, economic and political aspects of society, in paid and unpaid roles and in domestic, family and community life
- lower costs related to medical treatment and care services. (WHO, 2002)

1.3 International Developments in Healthy Ageing

1.3.1 Global Ageing

In the past few decades, much attention has been focused on the phenomenon of ageing, and its social, economic and political implications worldwide. Prior to this while some individuals may have lived to old age, their number and proportion in the total population was not high. The twentieth century, however, with its decreasing fertility rates and increasing longevity, has witnessed a dramatic increase in both the absolute number and proportion of people surviving into old age. This increase will continue in this century. While the world's population as a whole is projected to increase quite dramatically in the coming decades, it will be substantially less than the increase in older people with the result that while today one out of every ten persons is aged sixty years or older by 2050 this ratio will have increased to one out of every five persons (UN, 2002).

1.3.2 International Conferences on Ageing

1.3.2.1 World Assemblies on Ageing

A number of international organisations and individual countries have attempted to address the issue of the ageing of the population. The Vienna International Plan of Action on Ageing (now generally known as the 'International Plan') was one of the first international instruments on ageing. It was adopted in 1982 at the First World Assembly on Ageing in Vienna, having been approved in the same year by the United Nations. The aim of the International Plan was to 'strengthen the capacities of Governments and civil society to deal effectively with the ageing of populations and to address the developmental potential and dependency needs of older persons' (UN, 1982). The Plan included sixty-two recommendations covering the following broad areas:

- health and nutrition
- protection of elderly consumers
- housing and environment
- family
- social welfare
- income security
- employment and education.

In 1991, the UN General Assembly, adopted the United Nations' Principles for Older People, which consisted of eighteen principles relating to the status of older persons under the following headings:

- independence
- participation
- care
- self-fulfilment
- dignity.

In 1997, the UN General Assembly decided to observe the year 1999 as the International Year of Older Persons, and later decided to arrange a Second World Assembly on Ageing in 2002. The objective of the Second Assembly was to review the success, or otherwise, of the First Assembly and to adopt a revised plan of action as well as a long-term strategy on ageing. As a contribution to the Assembly the WHO developed a policy document entitled *Active Ageing: A Policy Framework* in an attempt to inform discussion and formulation of action plans that promote healthy and active ageing (WHO, 2002). The Framework recognises that a broad range of factors affect active ageing (including health and social services, behavioural determinants, personal determinants, physical environment, social determinants, economic determinants, gender and culture) and all these factors must be addressed in order to ensure active ageing. This Framework along with the Madrid International Plan of Action on Ageing (UN, 2002) was ratified and adopted by member states including Ireland in 2002. While recognising that the foundation for a healthy and enriching old age is laid early in life, the Plan is intended to be a practical tool to assist policy-makers to focus on the key priorities associated with individual and population ageing.

1.3.2.2 The Ottawa Charter

The first International Conference on Health Promotion in Ottawa (WHO, 1986) proposed a framework through which population health can be improved. This framework recognised that the major determinants of health exist outside the health services and that health promotion has a role in reducing health inequalities. The Ottawa Charter lies at the core of *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) and is used in this Report both in the consideration of case studies in Chapter Five and in the considerations of implications for the future direction of healthy ageing in Chapter Eight.

The Ottawa Charter sets out five directions for improving the health of populations, which are listed below with a brief descriptive note putting these directions in the context of healthy ageing and this project in particular.

Building Healthy Public Policy

The development of healthy policy would include changes to legislation, taxation and fiscal policies that can promote health and equality in later life, as well as challenging policies based on ageist assumptions.

Creating Supportive Environments

The creation of enabling physical and social environments is of paramount importance to healthy ageing, having the capacity to mediate the difference between independence and dependence and between autonomy and restriction. This has particular implications for planners of the built environment including housing, recreational amenities and other infrastructure such as transport.

Strengthening Community Action

Health promotion works effectively if people are empowered to take ownership of their own health and that of their community. *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) referred to the need to identify factors which inhibit community projects and initiatives. These factors were uncovered in this research process by those parties involved in the practical planning, operation and evaluation of healthy ageing initiatives.

Developing Personal Skills

In order to achieve the central aim of health promotion, that of 'enabling people to increase control over, and to improve their health' (WHO, 1986), the older individual should be supported through the provision of appropriate information, and life skills to adapt to transitions in later life.

Reorienting Health Services

The health services in Ireland are changing, with an increased focus on prevention (DoHC, 2001a) and person-centred care (DoHC, 2001b); two principles at the core of the last tenet of the Ottawa Charter. Challenges remain, for example, in terms of ensuring person-centred care for older people in residential care (Mangan, 2003).

1.3.3 Healthy Ageing Developments in Canada

As well as these international organisations, individual countries have taken a proactive role in response to demographic changes for a number of years. In 1998, in Canada, a National Framework on Ageing (NFA) was approved to assist in responding to the needs of an ageing population. The Framework facilitates the application of a 'seniors lens' to Government initiatives at all levels in order to ensure that the perspectives and needs of seniors are considered (Health Canada, 2002). The Framework states that 'Canada, a society for all ages, promotes the well-being and contributions of older people in all aspects of life' and sets out five principles (dignity, independence, participation, fairness and security) to guide the actions necessary to achieve its vision (Health Canada, 2002).

1.3.4 Healthy Ageing Developments in Australia

Since 1999, the Office for an Ageing Australia, in collaboration with Commonwealth Departments, State/Territory Governments and international organisations, has addressed a wide range of issues relevant to the ageing of Australia's population. The Commonwealth Government has developed a National Strategy for an Ageing Australia. This Strategy includes a broad framework which identifies the challenges and possible responses for Government, business, the community and individuals to meet the needs of Australians as they age (Andrews, 2002). The following issues are addressed:

- healthy ageing (incorporating diet, exercise, smoking, education, income and social status)
- independence and self-provision
- mature age works
- world-class care and attitudes
- lifestyle
- community support.

1.3.5 Healthy Ageing Developments in the USA

A wide variety of organisations, both governmental and non-governmental, have addressed the issue of ageing in the USA. The Healthy People 2000 Strategy detailed twenty-two priority areas and set over thirty specific targets related to health promotion with older people. The targets were divided into four key areas:

- health status objectives targeting older people
- risk reduction objectives targeting older adults
- key services and protection objectives targeting older adults
- related objectives from other priority objectives including physical activity, nutrition, tobacco, alcohol, mental health and disorders etc.

This Strategy marked an important development for the health of older Americans. The specific targets provided information on current status of older people in various areas and information on what is aspired to. In addition, the targets allow the success or otherwise of the Strategy to be judged by determining if the targets have been achieved or not. However, while the Strategy was concerned with promoting the health of older people, much of the emphasis is placed on the role of the health sector in determining health, to the detriment of all other factors which legitimately impact upon older people's well-being and quality of life. The most recent health strategy, Healthy People 2010, specifies seventy-six objectives in relation to the health of older adults. Once again, these objectives seem to be disproportionately concentrated in the area of the health sector.

The Centre for Disease Control and Prevention (CDC) is recognised as the leading governmental agency for protecting the health and safety of people in the US. Its healthy ageing programme has the following aims:

- to provide quality information and resources that consumers, health care providers and ageing experts want and need
- to support the health care systems prevention efforts
- to bring together public health agencies prevention expertise with the Administration on Ageing (AoA) services network
- to help communities identify and put in place what works in prevention
- to monitor changes in the health of older Americans.

The Healthy Ageing Research Network funded by the CDC was established to assist with the development of a research and dissemination agenda related to the public health aspects of healthy ageing. It defines healthy ageing as 'the development and maintenance of optimal physical, mental and social well-being and function in older adults'. This is most likely to be achieved when physical environments and communities are safe, when attitudes and behaviours known to promote health and well-being are followed and by the effective use of health services and community programmes to prevent or minimise the impact of acute and chronic disease on function. In this regard the CDC has developed Network whose mission is 'to better understand the determinants of healthy ageing in older adult populations; to identify interventions that promote healthy ageing; and to assist in the translation of such research into sustainable community-based programmes throughout the nation'.

There is a strong emphasis in the US on translating the research that has been done into evidence-based intervention programmes. Recently the AoA offered grants in the region of $200,000 to $250,000 to programmes which seek to determine how the health and quality of life of older people can be maximised by translating previous research into evidence-based intervention models that prevent or delay the progression of disability and/or disease.

1.3.6 Healthy Ageing Developments in the UK

In the UK, the National Service Framework for Older People (NSF) produced by the Department of Health in 2001 set new national standards of care for all older people, whether they live at home, in residential care or are being cared for in hospital. Its aim, backed by £1.4 billion extra to be invested every year up to 2004, is for better health and social care services for older people through:

- high-quality care and treatment regardless of age
- the treatment of older people as individuals, with respect and dignity
- equitable resourcing for conditions which affect most older people
- easing the financial burden of long-term residential care.

Eight standards underpin the NSF:

- rooting out age discrimination
- person-centred care
- intermediate care
- general hospital care
- stroke
- falls
- mental health in older people
- promoting an active healthy life in old age.

An important objective of the Framework is to increase the healthy life expectancy of older people, based on the assumption that the modification of risk factors for disease even late in life can have health benefits for the individual which include longer life, increased or maintained levels of functional ability, disease prevention and an improved sense of well-being. In an attempt to achieve this standard a number of principles have been set out:

- older people should have access on the basis of need, not age, to health promotion activities announced in the Mental Health NSF, Coronary Heart Disease NSF and the NHS Cancer Plan

- active support for health promotion activities that are of specific benefit to older people including those concerned with increasing physical activity, improving diet and nutrition, and immunisation and management of influenza

- wider initiatives to reduce poverty and improve housing and local amenities, including transport.

The NSF marks an important step forward in establishing better health and social care services for older people in the UK. It is, for example, the first time that prevention is accorded the same priority as health services provision. The Framework is, however, not without its critics. Glendinning *et al*. (2002) point out, that for the development of the NSF, an independent advisory group of older people was convened to provide a user perspective and that the priorities identified by the group differ from those which finally emerged in the Framework. While some priorities such as the ending of unequal treatment because of ageism are common to both groups, the user group raised a number of issues that were not addressed in the framework. The user groups were more concerned with a holistic approach to the quality of life of older people which would, fundamentally involve the older people themselves in the planning, organisation and monitoring of services.

1.4 Life Expectancy of Older People

1.4.1 Life Expectancy of Older People Internationally

While interest in older people generally has increased over the past few decades, it is difficult to determine if this interest has been translated into actual improvements in their situation. Unfortunately it is very difficult to create a measure that captures quality of life and changes in quality of life of older people over time in an international perspective[4]. The measure that is most often used (although it does not meaningfully capture quality of life) is life expectancy (the average number of years of life remaining to a person of a particular age). The WHO provides information on life expectancy at 65 years of age for a selected

4 An attempt to develop a measure to assess quality of life of older adults, entitled WHOQOL-OLD, is currently underway supported by the WHO and the European Union Framework 5 Programme. Further details available at http://www.who.dk/ageing/Quality/20020710_1.

number of European countries. Data is available for 1990 and 1999, which allows cross-country comparisons to be made on life expectancy for older people, as well facilitating a limited exploration of trends over time (Tables 1.1 to 1.3).

Table 1.1: Life expectancy at age 65 for the years 1999 and 1990

Country	Life expectancy at age 65 in 1999 (in years)	Ranking	Life expectancy at age 65 in 1990 (in years)	Ranking
France	19.21	1	18.69	1
Switzerland	19.13	2	17.77	2
Italy	18.70	3	17.31	5
Sweden	18.43	4	17.46	4
Spain	18.39	5	17.54	3
Luxembourg	18.19	6	16.49	11
Austria	18.06	7	16.77	10
Greece	18.02	8	17.07	6
Germany	17.88	9	16.36	12
Norway	17.83	10	16.84	9
Finland	17.72	11	16.24	14
Belgium	17.52*	12	16.85	8
Netherlands	17.46	13	17.05	7
UK	17.22	14	16.35	13
Denmark	16.80	15	16.17	15
Portugal	16.27	16	15.71	16
Ireland	**15.97**	**17**	**15.21**	**17**
EU average	**18.08**		**17.06**	

* Data refers to 1996 – latest availability for Belgium

Source: WHO Regional Office for Europe (http://hfadb.who.dk/hfa/)

Based on this data, it is clear that the life expectancy of older people in the European Union is improving over time. People reaching the age of 65 can now expect to live an additional 18 years on average, compared to 17 years in 1990, an increase of a year over the decade. The improvement for males between 1990 and 1999 is slightly higher than for females though the difference between males and females is not significant. Life expectancy for females at 65 years is nearly four

years higher than for males in the European Union. France has the highest life expectancy for older people for 1990 and 1999 at 18.69 years and 19.21 years respectively. The improvement in life expectancy is associated with the decrease in death rates among those aged over 65 from various diseases. The age-standardised death rate from diseases of the circulatory system for those aged over 65 has decreased 43 per cent between 1970 and 1999. Similarly death rates from ischaemic heart disease have decreased by 30 per cent for the same age group.

Table 1.2: Life expectancy for males at age 65 for the years 1999 and 1990

Country	Life expectancy at age 65 in 1999 (in years)	Ranking	Life expectancy at age 65 in 1990 (in years)	Ranking
Switzerland	16.95	1	15.39	5
Greece	16.79	2	15.83	2
France	16.68	3	16.14	1
Sweden	16.53	4	15.43	4
Italy	16.37	5	15.12	6
Spain	16.19	6	15.50	3
Austria	15.98	7	14.57	8
Norway	15.76	8	14.67	7
Luxembourg	15.68	9	14.20	12
Germany	15.68	10	14.10	13
UK	15.43	11	14.22	11
Finland	15.28	12	13.83	16
Denmark	15.17	14	14.07	14
Netherlands	15.25	13	14.47	9
Belgium	15.10*	15	14.42	10
Portugal	14.35	16	14.02	15
Ireland	**14.17**	**17**	**13.25**	**17**
EU average	**15.92**		**14.84**	

* Data refers to 1996 – latest availability for Belgium

Source: WHO Regional Office for Europe (http://hfadb.who.dk/hfa/)

Table 1.3: Life expectancy for females at age 65 for the years 1999 and 1990

Country	Life expectancy at age 65 in 1999 (in years)	Ranking	Life expectancy at age 65 in 1990 (in years)	Ranking
France	21.32	1	20.77	1
Switzerland	20.90	2	19.74	2
Italy	20.62	3	19.11	6
Spain	20.31	4	19.23	5
Luxembourg	20.12	5	18.19	10
Sweden	20.11	6	19.30	3
Norway	19.66	7	18.78	8
Finland	19.57	8	17.91	14
Austria	19.56	9	18.20	9
Belgium	19.54*	10	18.87	7
Germany	19.47	11	17.81	15
Netherlands	19.31	12	19.24	4
Greece	19.13	13	18.16	11
UK	18.73	14	18.11	12
Denmark	18.17	15	18.04	13
Portugal	17.88	16	17.14	16
Ireland	**17.64**	**17**	**17.08**	**17**
EU average	**19.83**		**18.79**	

* Data refers to 1996 – latest availability for Belgium

Source: WHO Regional Office for Europe (http://hfadb.who.dk/hfa/)

Table 1.4: Healthy life expectancy at age 60 for the year 2000*

	Male	Female
Australia	16.4	18.8
Austria	15.7	18.5
Belgium	14.8	17.8
Canada	15.3	17.9
Denmark	15.5	16.7
Finland	15.2	18.1
France	16.1	19.1
Germany	15.0	17.7
Greece	15.7	17.1
Iceland	16.8	17.6
Ireland	**13.9**	**16.1**
Italy	15.5	18.2
Japan	17.1	20.7
Luxembourg	15.1	18.3
Netherlands	15.0	17.3
New Zealand	15.9	17.7
Norway	15.6	17.9
Portugal	13.4	16.2
Spain	15.2	18.2
Sweden	16.5	18.5
Switzerland	16.9	19.4
UK	15.0	16.9
USA	14.9	16.6

* Healthy life expectancy is based on life expectancy but includes an adjustment for the time spent in poor health.

Source: The World Health Report 2001 (WHO, 2001)

1.4.2 Life Expectancy of Older Irish People: Adding Years to Life

The situation for older people in Ireland is less satisfactory. If we use life expectancy as an indicator of health status, older people in Ireland emerge as having relatively poor health when compared to their EU counterparts. As Table 1.1 shows, Ireland ranked lowest among seventeen European countries in 1999 in life expectancy at age 65, with a gap of 2.11 years between Ireland and the EU average. Perhaps even more worrying is that this gap appears to be increasing over time, having increased from 1.85 years in 1990. While this deterioration in the relative position of Ireland is apparent for both males and females (Tables 1.2 and 1.3) it seems to be driven by a worsening in the relative position of females, who are falling behind their EU counterparts faster than are Irish males. Women aged 65 years in Ireland live longer than their male counterparts, but the life expectancy gap between them and similarly aged women in Europe is widening.

1.4.3 Healthy Life Expectancy of Older Irish People: Adding Life to Years

Life expectancy is, of course, only one part of the equation: quality of life also matters. In a WHO healthy life expectancy ranking of twenty-three developed countries, Ireland ranked twenty-second for males (with only Portugal performing worse) and twenty-third for females (Table 1.4). Quality of life is measured by the time spent in poor health by people aged 60 in the countries covered by the survey. France once again performs very well in this survey but is beaten into second place by Japan which tops the healthy life expectancy table for both males and females. The gap between Ireland and Japan for healthy life expectancy is 3.2 years for males and 4.6 years for females. Older women in Ireland again perform poorly relative to their European counterparts.

At present we know little about the causes of Ireland's relatively poor position, particularly for older women. There are pointers as to why general life expectancy in Ireland is poor relative to other European countries. These include the following:

- Irish age-standardised death rates for people aged 65 years and over from cardiovascular disease and stroke are above the EU average
- rates of lung and colon cancer exceed the EU average
- respiratory deaths are higher in Ireland than in the rest of the EU
- alcohol consumption is relatively high in Ireland
- poverty and deprivation for older Irish women is relatively high compared to other EU countries.

A broad range of factors impact upon health and life expectancy including health services, behavioural factors, personal factors, the physical and social environments, as well as economic and cultural determinants. Brenner and Shelley (1998) discuss the possible contributions of lifestyle factors, and the physical and social environments, to the high mortality rate of older people in this country. They identify a number of risk factors including smoking, nutrition and diet, physical activity, alcohol, housing, security, transport, atmosphere and sunlight, water, attitudes and income. For example, obesity is identified as a health problem for both older men and women in Ireland. Obesity is a significant risk factor for the development of high blood pressure, high cholesterol levels and diabetes, which all contribute in turn to an increased risk of developing heart disease and stroke. In their study, Fahey and Murray (1994) revealed that half of all males and almost half of all females in the 65 to 74 age group were either overweight or obese, and recent studies would suggest that Ireland is facing into an obesity epidemic across all age groups (DoHC, 2002a).

1.5 Healthy Ageing Policies in Ireland

1.5.1 A Health Promotion Strategy for Older People

Historically, healthy ageing and health promotion for older people did not receive much attention from policy-makers in Ireland. This began to change in the late 1980's and early 1990's with the publication of *The Years Ahead: A Policy for the Elderly* (Working Party on Services for the Elderly, 1988). The report clearly stated that a successful policy of health promotion would reduce the incidence of disease and handicap among older people and increase the number of older people who are healthy and active. In 1994, Fahey and Murray made a recommendation to the Minister for Health that a health promotion strategy for older people be considered a priority. In the same year *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s* (DoH, 1994) proposed that priority be given to the promotion of healthy ageing with the assistance of the NCAOP, in cooperation with statutory and voluntary bodies associated with older people.

In 1995, the Department of Health published a detailed strategy for the promotion of health in Ireland. While much of the emphasis was on preventing premature mortality in the population as a whole, older people were identified as a priority population. The goal in relation to older people was to increase the proportion of

older people who enjoy an active, independent and healthy old age. One means of doing this was through the establishment of a national programme to promote healthy ageing in Ireland. *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998), published by the NCAOP in conjunction with the Health Promotion Unit of the Department of Health and Children marked the beginning of the Healthy Ageing Programme. The objectives of the Strategy, which were set out at the beginning of this Chapter, focused on life expectancy, health status and autonomy for older people. It also recognised that the promotion of health for older people is not solely a matter for the Department of Health and Children, but for all Departments and organisations whose policies and actions may potentially have an impact on the health of older people.

Goals, targets and recommended action plans were presented on specific diseases, accidents and suicides, lifestyle, physical and social environments. By and large, the goals are of a very general nature. While twenty-four goals are specified, only four specific targets dealing with cardiovascular disease, cancer, accidents and smoking are given, compared to thirty in the AoA's Healthy Ageing 2010. The failure to provide specific targets makes it very difficult to determine if the goal in question has been achieved or not.

Specifying targets involves having information on the current prevalence or incidence of the disorder/factor in question and knowing what can legitimately be achieved within a given timeframe given present resources. This information is absent in most of the areas covered by the Strategy, for example in respect of vision, hearing and musculoskeletal disorders. The exclusion of older people from studies that have been done to date is sometimes informed by un-challenged ageist thinking which excludes older people on the basis of age only. There is also an absence of longitudinal and cohort studies on the life-course and the relative contributions of interventions earlier in life to healthy ageing. Lack of information in this regard is not a sufficient excuse to exclude targets, but rather should act as a stimulus to policy-makers to gather such information.

Furthermore, the twenty-four goals provided are done so without prioritisation, therefore we cannot identify which are most important. Given limited resources, it is highly unlikely that all objectives can be achieved in a short period of time. Some sort of ranking is required which would allow us to determine which goals are most important and should receive priority when resources are being allocated. This, in turn, requires a commitment to evaluation, which has not been a general feature in health and social care in Ireland. The most fundamental objective should be to increase life expectancy at 65 years of age for older people in Ireland,

thereby reducing the gap in this measure between this country and the rest of Europe. The second objective should be to increase quality of life and well-being for older people in the country. There is currently not enough information on how best to achieve either of these goals given scarce resources.

The first strand of the Healthy Ageing Programme was the development of the *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998). The second and third strands involve supporting the implementation of the Strategy through various means including the development of an information and support network for promoting the health, welfare and autonomy of older people, as well as identifying and promoting models of good practice for healthy ageing. There is, however, no uniform approach to health promotion for older people across the country. Some health promotion departments have health promotion officers for older people but the majority do not. There is no requirement for public health/health promotion departments to report progress in relation to the Strategy to a central body and no specific agency has been charged with the task of monitoring its implementation.

1.5.2 Other National Health Strategies and Reports

Alongside the development of a Health Promotion Strategy for Older People, the Government and various statutory organisations have produced a number of reports which deal directly or indirectly with the health and quality of life of older people in Ireland. As the names suggest, the National Cancer Strategy (DoH, 1996) and the National Cardiovascular Strategy (DoHC, 1999) deal with the issues of cancer and heart disease in Ireland.

1.5.2.1 National Cancer Strategy

Generally the National Cancer Strategy deals adequately with the issue of cancer and older people. There is one exception to this, however, concerning the policy regarding breast cancer screening for women over 65, who are entitled to screening on request but are not called automatically by letter. Many older women believe that they are not at risk of breast cancer, with 25 per cent of over 70's believing they are too old to develop breast cancer (Gunfeld *et al.,* 2002). However a women's risk of breast cancer increases considerably with age from approximately 1 in 50 up to age 50, to 1 in 15 at age 70. Some women may conclude that because they are no longer routinely invited to attend breast screening after a certain age, they are no longer at risk of breast cancer (Ipsos-UK, 2002, 2003). It is legitimate to pose the question, therefore, whether the failure to provide population screening for breast cancer for women over 65 years of age represents a form of ageism in the healthcare system (O'Neill and O'Keefe, 2003; The Pennell Initiative, 1997).

1.5.2.2 National Cardiovascular Strategy

Older people suffer most of the mortality and morbidity caused by heart disease. As well as being the number one cause of death, cardiovascular disease is a major risk factor for declining mobility, loss of independence, poor quality of life and mental illness (Guralnik and Fried, 1997). The reduction in the number of younger people experiencing a first heart attack has been rivalled by an epidemic of heart failure i.e. the weakening of the heart that occurs after the first heart attack (Davis *et al.,* 2000). The National Cardiovascular Strategy has a focus on primary prevention i.e. the prevention of the first heart attack. There is a need for more attention to be focused on heart failure, which disproportionately affects older people. Concern was also expressed in a number of submissions to the Cardiovascular Health Strategy Group that older people are not benefiting as they should from advances in treatments for cardiovascular disease. There is a considerable evidence base to support this view (Dudley and Burns, 1992; Whelan, 1998; Little, 1999) but the issue has not been investigated in Ireland. The capping of recommendations for blood pressure management at age 65 is contradictory to a large evidence-base (Ebrahim and Davey Smith, 1996; Collins *et al.,* 1990; Medical Research Council Working Party, 1992) and also to the recommendations of the Health Promotion Strategy for Older People which states 'there is strong evidence that medical treatment of hypertension (high blood pressure) at least up to the age of 80 years, is effective in reducing the risk of both stroke and heart disease' (Brenner and Shelley, 1998). Future trials of the effects of preventive interventions should also avoid age restrictions.

1.5.2.3 National Health Strategy

The most recent National Health Strategy *Quality and Fairness: A Health System for You* (DoHC, 2001b) does not specify older people as a group that deserves special consideration but does describe the implications of the Strategy for older people. The need for acute healthcare provisions for sick older people and active health maintenance programmes for continuance of health in older people are highlighted. A number of actions under the headings of better health for everyone, fair access, responsiveness, and appropriate care delivery and high performance are outlined. However, one serious shortcoming of the Strategy is its narrow focus on the healthcare system. While the report does address the wide set of factors which potentially impact upon health generally, this analysis seems to be downplayed when it comes to addressing the health of older people. In order to increase life expectancy at 65 to the European average level, it is necessary to move away from this narrow focus on the healthcare system to address all the factors which potentially impact on the health of older people.

1.5.2.4 Nutrition

In 2000, the Food Safety Authority of Ireland (FSA) produced a report on the issue of nutrition and older people in Ireland. This report recognised that for older people (as for the general population) the maintenance of good health depends on safe, affordable and appropriate foods. The link between diet and various causes of ill health and premature mortality such as heart disease, stroke, cancer, obesity and arthritis was highlighted. The report recognised the need for multisectoral action when dealing with the health of older people as an appropriate diet requires an adequate transport system, advice on nutrition, an adequate level of income etc. Nutrition intervention is thought to be a cost-effective exercise for healthcare providers. A number of recommendations were made in this regard including a call to the Department of Health and Children (DoHC) to take the lead role in coordinating action to improve the nutritional status of older people. Unfortunately, since the publication of the report almost three years ago, very little progress has been made with regard to the implementation of any of the recommendations. Reports of this kind are very important for the health and quality of life of older people, but there is a need for a commitment that research reports of this kind will be translated into action.

1.5.2.5 Ageism and Equality

In 2002, the Equality Authority published a report entitled *Implementing Equality for Older People* which sought to examine and expose the issue of ageism in Ireland, and put forward an equality agenda with a capacity to change the situation and experience of older people. The recommendations in the report are built around key strategies as follows:

- age-proofing decisions for their impact on older people
- positive action to address a history of exclusion of older people
- participation by older people and their organisations in decision-making that affects them
- training in age awareness and skills in combating ageism
- underpinning key services through legislative entitlements.

These are important issues which deserve more consideration than they have so far been given. The key issue is implementation. Effective strategies require complementary structures for planning and monitoring to ensure that good policies are implemented.

One important policy issue for healthy ageing, which is not addressed in any of the reports mentioned so far, concerns those people who do not reach the age of 65. Each year thousands of people die prematurely and never have an opportunity to experience old age. There are many reasons why people die before reaching old age, but one important factor is socio-economic status. Recent work shows that those from manual groups have a substantially higher mortality rate than those from non-manual groups, and more worryingly, this differential appears to be increasing over time (O'Shea, 2003). Learning from the experience of other countries a wide range of factors including living and working conditions and lifestyle factors are likely to have a part to play in this. Lower income groups are several times more likely to adopt unhealthy behaviours particularly in relation to smoking, physical inactivity and unhealthy diet (DoHC, 2002). Many of the reasons why people from lower socio-economic groups experience more premature deaths are, therefore, preventable and amenable to policy intervention. One of the underlying tenets of any healthy ageing programme should be ensuring that everybody has an equal opportunity to reach old age.

1.6 Conclusions

Increased life expectancy and declining birth rates are combining to make the population of most developed countries older than ever before. This will have profound implications for the healthcare and pensions systems of these countries. However, our concern here is to ensure that the additional years that people are living are both enjoyable and fulfilling for them. A number of attempts have been made internationally, and in more recent times in Ireland, to ensure that this is the case. The development of the Healthy Ageing Programme by the NCAOP is an important step in this regard. So too is the work of statutory organisations such as Food Safety Authority and the Equality Authority. However, the fact remains that the position of older people in Ireland relative to other countries, as measured by life expectancy and healthy life expectancy, has deteriorated in the past decade. Quite clearly not enough is being done to improve the health and well being of older people in Ireland. We remain at the bottom of the life expectancy table in

Europe and things have got worse not better in recent years. The major goal of healthy ageing policy in the coming years should be to reduce the gap in life expectancy at 65 years of age between Ireland and the rest of Europe.

A more integrated and multisectoral public policy is required to improve the health of older people. All organisations that potentially impact upon the quality of life of older people should work in harmony to ensure that healthy ageing is achieved. There is a need to move away from a one-dimensional curative approach to issues concerning older people towards a more holistic model that recognises the multidimensional nature of health and well-being. There is also a need to specify targets in relation to the health of and heath promotion for older people, something that is missing in *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998). Specifying targets and instruments, as well as providing clear aims and objectives, will allow us to evaluate the success or otherwise of healthy ageing programmes in the future.

We must also ensure that healthy ageing is not only confined to people in good health. Successful ageing is also possible for people with disease and disability because concepts of dignity, respect, autonomy and social engagement are essential ingredients of the 'good life', irrespective of the health and mental condition of older people. One of the difficulties is that we know very little about what older people value most as they grow older, or what works in respect of healthy ageing for older people. While considerably more research is required on the values question, this Report attempts to document what is currently available to older people in the field of healthy ageing.

Chapter Two
Methodology

Chapter Two
Methodology

2.1 Introduction

This chapter provides details on the methodology used to examine policy, practice and evaluation with respect to healthy ageing in Ireland. There have been a number of initiatives to promote the health of older people in response to the problems identified in the previous chapter. These originate from both the statutory and voluntary sectors. In addition, there are community initiatives for older people that encourage participation in a range of social and cultural activities, as well as initiatives directed at improving older people's lifestyles. There are also programmes that aim to improve the environment in which older people live and a variety of other programmes concerned with health and mental well-being. There is, however, no comprehensive database of these activities, nor is there much by way of information on best practice or evaluation in the field of healthy ageing in Ireland.

The aim of this project is to generate a comprehensive Healthy Ageing Database and to produce a study that provides criteria for best practice and evaluation that will inform practitioners and policy-makers alike, resulting in improved health and social outcomes for older people in this country. The development of models of best practice for the future is the logical extension of the data generation exercise and is an important dimension of future resource allocation in this field. Similarly, providing an evaluation framework will allow worthwhile projects to be more readily identified and rewarded.

2.2 Methodological Issues

The most serious methodological issue to be addressed in the course of the project was the generation of a comprehensive list of contacts for healthy ageing projects in Ireland. If we were to successfully develop a database, we needed to know where to send the postal questionnaires. However, there was no list of healthy ageing activities or contact persons available to the project team at the start of this project. The NCAOP had a limited directory of projects generated from previous research but some of these had been discontinued, none were from the Eastern Regional Health Authority (ERHA) and it was desirable that this coverage be extended. The project team addressed the lack of a population frame in three ways, by:

- working with a senior health board contact person to generate an initial list of contacts in each health board region
- trawling existing but fragmented information sources of voluntary and statutory agencies
- working with the individuals who attended the regional seminars (see Section 2.2.1.2) to obtain detailed lists of contacts in each region.

The research brief demanded more than simply an extension to the existing database. There was a desire for both quantitative and qualitative information on what practitioners felt about healthy ageing policy and practice in Ireland. Acquiring this information would require greater direct contact with people running healthy ageing projects and services than simply using a postal questionnaire. Practitioners had to be centrally involved in the process and some mechanism had to be found whereby their views could be heard directly. It was decided to undertake a series of seminars in each of the health board regions. These seminars were designed to facilitate the process of intersectoral working and discussion, and were part of a 'bottom-up philosophy' to the generation of data for the database and report. The involvement of practitioners, including older people, in the information-gathering process provides an essential legitimacy for what follows.

2.2.1 Regional Seminars

Eight regional seminars were held between the end of January and the middle of March 2003. One seminar was held for the area covered by the three health boards in the ERHA region. One seminar was held in each of the Western, North Eastern, Southern, North Western, South Eastern, Mid-Western and Midland health board areas. The purpose of the regional seminars was to:

- bring together representatives of healthy ageing projects from health boards, voluntary groups, community groups, local authorities and older people
- generate discussion that would inform national best practice in the field of healthy ageing for older people
- obtain a comprehensive list of contact persons and addresses for all healthy ageing projects in the region
- facilitate communication and networking in the field of healthy ageing.

2.2.1.1 Planning and Organising the Regional Seminars

The project team invited the Chief Executive Officer of each health board to nominate a contact person within the health board with whom the team would work to organise a seminar. The contact person appointed was generally a senior manager in either the Services for Older People or Community Care divisions. An initial meeting with the contact person outlined the background to the Healthy Ageing Database and the aims of the seminar. The aim was to have forty to fifty participants at each seminar, with a slightly larger number at the ERHA seminar.

The project team outlined the potential participants, including representatives from known innovative projects within the region, a cross-section of health board personnel, including individuals with a specific interest in innovative healthy ageing activities, and a cross-section of participants from the community and voluntary sectors. The list of potential participants that the research team gave to each contact person at the initial meeting, as a starting point for generating the list of invitees for each seminar are shown in Tables 2.1 and 2.2.

Table 2.1: List of potential health board participants

Health board participants are likely to include a representative of the following:
■ Managers/directors of services for older people
■ Health promotion officers for older people
■ Other health promotion officers – choosing those who are particularly active with older people depending on your health board
■ Suicide prevention
■ Mental health for older people
■ Geriatricians
■ Psychiatry of old age
■ Day care
■ Public Health Nurses
■ Long-stay residential care, including any activity nurses/special programmes
■ Private nursing homes
■ Acute services
■ Nursing
Depending on activities in your health board, participants may include a representative of the following:
■ Falls preventions/accident prevention
■ Public health
■ Asylum seekers/refugees – from within health board or outside
■ Occupational therapists – someone with a specific interest in older people
■ Social workers with an interest in older people's issues
■ Audiology
■ Ophthalmics
■ Chiropody
■ Health Promoting Hospitals Network – health promotion officer within hospital
■ Carers' programmes/carers' training

Table 2.2: List of potential non-health board participants

Participants may include a representative from some of the following:
■ Local authority with an interest/involvement with older people
■ County Development Board with an interest/involvement with older people
■ Department of Social, Community and Family Affairs representative – interest in pensions, fuel allowances, widow(er)'s pensions, special needs cases/special diets etc.
■ Alzheimer's associations
■ Sheltered housing: voluntary sector or local authority
■ Sheltered housing or retirement housing: private enterprise
■ Representative from any national organisations e.g. Respond
■ Local county council/planning department
■ Community-based transport initiatives within the region
■ Private leisure centres/gyms – particularly those with focus on older people
■ Drama/Arts/Dance/Bealtaine – representative of any key local activities/initiatives
■ Catering services
■ Widow's/Widower's Association – if active locally
■ Volunteer bureau/Volunteering Ireland – any group training older volunteers
■ Active Retirement Association
■ Older Men's or Women's Network
■ Lions Club
■ Libraries – any activities for older people
■ VECs and life-long learning
■ Organised by older people
■ Outreach department of universities etc.
■ Local university or institute of technology: anyone involved in research about older people e.g. in physical activity, in assistive technology
■ Security/fire prevention: representative from Garda Síochána, Muintir na Tíre/ Community Alert organisations/ National Safety Council
■ Grocery shopping: any initiatives to make shopping easier (smaller-sized portions, fresh vegetables locally etc.) local grocers, RGDATA
■ Retirement planning groups – trade union-based, employer-based
■ Any publications/information dissemination that either include older people in preparing the information OR that emphasise older people as a target audience
■ Other relevant organisations headquartered or particularly active in your area.

The contact person within each health board area drew up a list of potential health board participants, based on the suggestions shown in Table 2.1. The contact person and the project team drew up a list of potential participants from outside the health board based on the suggestions shown in Table 2.2. As well as balancing participants from health board, voluntary and statutory sectors, the team aimed to balance representatives across the geographical regions within a health board region. We also wanted to ensure that in each seminar a cross-section of interests (both voluntary and health board) were represented, for example, community groups, specifically including Active Retirement Associations (ARAs), physical activity programmes and creative/artistic projects.

Relevant national organisations were also invited to send representatives: while many of these representatives attended the ERHA seminar, representatives of some organisations attended other seminars. As the seminars progressed, we paid specific attention to disciplines that had not yet been represented, for example, no one with a specific interest in either problems related to eyesight or in rural transport attended the early seminars, so the project team ensured that representatives from these areas were present at later seminars.

Invitations were issued to the potential participants and follow-up phonecalls were made to confirm attendance. The overview document included with the invitations to non-health board personnel to explain the background to the project and to the seminars is included in Appendix A. When an invited participant was unable to attend, that person nominated a representative or the project team sought out an alternative participant from that sector. Participants were asked to bring a list of contacts for healthy ageing projects known to them to the seminar.

2.2.1.2 Operation of the Regional Seminars

The regional seminars were based almost entirely around group discussions. Prior to each seminar, the participants were divided into groups of seven to nine people, mixing participants from different sectors (health board, voluntary and statutory), from different disciplines (for example, nursing, administration and voluntary) and different interest areas (for example, physical activity, social activities, housing and transport). When participants arrived at the venue, they immediately joined the groups to which they had been assigned. Dividing participants into groups from the beginning of the seminar maximised the networking opportunity for participants and also ensured that in each group, different perspectives were brought to each discussion. A facilitator was appointed to each group: facilitators were chosen with a view to balancing health board and non-health board participants and also to provide some geographical balance.

Each participant received a information pack, containing a list of all participants at the seminar and their organisations, a document outlining the issues to be discussed (Appendix B) and a comments sheet to provide feedback on the seminar (Appendix C).

Each seminar began with a brief introduction to the project and a definition of what the term 'healthy ageing activities' means (Appendix D). In each region, participants at the seminars were asked to consider the following major issues in relation to healthy ageing activities:

- current priorities
- future priorities
- issues in the planning, development and operation of healthy ageing projects and services
- best practice.

There was extensive discussion on each of these issues within the groups. Verbal feedback was gathered from them during the seminar and discussed. Written feedback was also collected from the groups and from some individuals at the end of the seminars.

Finally, we collected lists of contacts for healthy ageing projects that participants brought to the seminar. Participants from ARAs supplied the greatest number of contacts at the seminars, mainly for ARAs in the region. Other participants subsequently forwarded contact details for projects in their area, which seemed to reflect a positive reaction to participation in the seminar itself.

Overall, while the contact details provided through the seminars were invaluable, we did not generate as many contacts as we had hoped. This reflected the information deficit and fragmentation of information with respect to healthy ageing activities even within regions. Health board personnel provided contact details for other health board-run activities and some non-health board activities. Voluntary and statutory groups provided information about their own work but there was seldom any cross-over – in particular, the voluntary and statutory groups provided almost no detail of activities outside of their immediate remit.

2.2.2 Survey Questionnaire

2.2.2.1 Pilot Questionnaire

The project team developed a pilot questionnaire, in conjunction with the NCAOP's Healthy Ageing Programme Advisor, which was then sent to the directors of nine known healthy ageing projects. We aimed to include a wide variety of projects and so the pilot sites included:

- a project running at national level with many local implementations
- a falls prevention project, an activity therapy project and an arts project in long-stay residential settings
- a very innovative ARA, which runs many different healthy ageing activities
- a sheltered housing project in a rural area
- a rural-based community group providing services to older people
- a voluntary organisation for older men
- an urban-based social services organisation.

Six of these returned questionnaires, describing a total of eleven projects (as some organisations were involved in more than one project). Having analysed the returned questionnaires, the basic structure of the questionnaire remained the same but some minor changes were made to the wording of questions and to the layout of some items of information.

2.2.2.2 Administration of Final Questionnaire

The project team then developed a list of contacts for the administration of the questionnaire. The list of contacts included the following:

- all the participants who attended the regional seminars. In cases where these people were in administrative positions within a health board, we asked them to forward the questionnaire to the managers of one or more innovative healthy ageing projects in their region

- every contact provided by participants at the seminars. These included contacts in a wide range of settings including day care centres, long-stay residential units and hospitals
- over 250 ARAs and other community-based organisations for older people
- national organisations including organisations working exclusively with older people such as Age and Opportunity, as well as organisations whose target population includes, but is not exclusively, older people such as the Irish Red Cross and the Irish Heart Foundation
- contacts provided by Citizen Information Centres (CICs). We contacted every CIC in Ireland and asked them to send us contact details for any organisations working with older people in their area
- statutory agencies including county council arts officers (27), county council housing officers (34), adult education officers in VECs (46) and all county librarians (33)
- geriatricians, including specialists in psychiatry of old age (50)
- health board dieticians (13)
- rural transport initiatives (34), community groups including Area Partnership Companies and local development groups (over 170 of these)
- Alzheimer day care centres
- key contacts for the Bealtaine festival
- voluntary housing schemes known to include older people among their residents
- a miscellaneous category of contacts in a variety of areas, which included accident prevention, animal organisations, bereavement care, cancer projects, carers organisations, creative projects, dental and oral projects, diabetes, disability, eyesight projects, GPs, hearing projects, home helps, homeless people, hospice care, hypothermia, incontinence, intergenerational projects, mental health, occupational therapy, older men, personal development, physical activity, physiotherapy, public health nursing, retirement planning, religious orders, Travellers, energy conservation, security and safety, sexual health, social programmes, social workers and stroke/stroke prevention.

Customised letters were written for different types of contact. For example, in the letter to national organisations who work with the general population including older people, we asked them to describe innovative aspects of their work that affected healthy ageing whereas the letter to a manager of a falls prevention programme in a hospital asked the recipient to complete the questionnaire specifically about the falls prevention programme. We also invited recipients of the questionnaire to provide information about more than one project, if they wished, and explained how this could be done. The questionnaire was also published on the website of the National University of Ireland, Galway, and could be completed and submitted online if required.

We initially printed and posted 1,300 questionnaires. Due to continued work on developing the list of contacts, it was necessary to print an additional 200 copies. We eventually used 100 of these making a total of 1,400 questionnaires posted to potential healthy ageing projects. Those who did respond to the questionnaire did so almost immediately and most of the returns occurred within the first month of the data collection process. Only questionnaires returned before the middle of July 2003 were included in the detailed analysis of healthy ageing projects contained in Chapter Four of this Report. There was ongoing and selective follow-up of known projects that did not respond to the initial questionnaire.

2.3 Conclusions

The objective of this element of the project was to generate a new and comprehensive Healthy Ageing Database of healthy ageing projects and activities in this country. Information was initially sparse and data had to be generated from the ground upwards. This was done through regional seminars and snowball sampling whereby information on potential projects was passed from interested parties to the research team. Similarly, little was known about best practice or the approach to evaluation in the healthy ageing field in Ireland. The seminars were designed to facilitate intersectoral discussion in both of these areas. The philosophy of the project was to involve all stakeholders in setting priorities for healthy ageing and in establishing criteria for best practice in the field. The seminars facilitated this process, supported by the postal questionnaire, which also invited respondents to give their views on priorities and best practice in the field of healthy ageing in Ireland.

Chapter Three

Priorities, Planning and Best Practice: Stakeholder Views

Chapter Three

Priorities, Planning and Best Practice: Stakeholder Views

3.1 Introduction

One of the most significant benefits of the regional seminars was the opportunity provided to participants to network with other organisations and individuals working with and for older people. As described in Chapter Two, we concentrated on ensuring that the list of invitees to the seminars included representatives from voluntary and statutory groups, including older people themselves, and a good cross-section of health board personnel. When dividing participants into groups for the seminars, we ensured that there was a mix of people from different backgrounds and organisations in each group. This focus ensured that participants met people from different backgrounds and listened to the opinion and perspective of those that they would not normally meet or talk to. Some very animated discussions ensued and the feedback on this aspect of the seminars was outstandingly positive. Comments such as 'I never thought about that issue from her point of view' or 'I didn't know that such a service is available in our area' are examples of the reactions of participants.

Participants in the seminars in each region were asked to consider the following major issues in relation to healthy ageing activities:

- current priorities
- future priorities
- issues in the planning, development and operation of healthy ageing projects
- best practice.

The questions on priority setting caused the most difficulty for participants who were not used to having to think about projects and services outside of their own particular areas of interest. It is interesting that participants complained about not having the information to make a considered judgement on current priorities. In general, despite the availability of health board plans and programmes, people working in the healthy ageing field did not know what was going on outside their own particular areas and certainly did not consider themselves as having any input into regional priority setting. Participants found it easier to list issues and problems in the planning, operation and development of projects and services with this part of the exercise taking the least time in all of the seminars. The discussions surrounding best practice were less conclusive with less definite views expressed regarding the central elements of best practice. Nevertheless, it was quite clear that the most important aspect of best practice for all groups was the involvement of older people in the planning and operation of projects and services, something that is not happening at the moment.

3.2 Current Priorities in Healthy Ageing

3.2.1 Disease-Related Projects

The view expressed at all regional seminars was that resources for healthy ageing are predominantly being spent in services and projects dealing with specific diseases, in particular heart disease and cancer. Just over 60 per cent of all seminar groups ranked 'specific diseases' as number one in terms of their perception of current priorities in their region. Participants were aware of the development of services and projects relating to the National Cancer Strategy and National Cardiovascular Strategy in recent years and felt these developments had been of benefit to older people. However, participants repeatedly expressed the view that resources were being spent on cure rather than prevention and on medication rather than health promotion for older people. Participants were also aware that current priorities in terms of lifestyle change focussed on health behaviours with respect to heart disease.

3.2.2 Residential Care Bias

The issue of care options was raised at each of the regional seminars. There was a general view that residential care dominated community care options for older people with respect to the care of dependent older people. Participants at the regional seminars expressed frustration that beds were too often seen as the sole response to the needs of dependent older people. While people acknowledged the need for long-stay beds, there was concern and resentment expressed in terms of the funding allocated for subventions to private nursing home residents in the past decade relative to the funding allocated to community care services. The question of funding was central to the discussion on priority setting with some parties pointing to the discrepancy between stated Government policy of keeping older people in their own homes and the continued bias towards residential care settings.

Frustration was expressed across the board in relation to the underdevelopment and inconsistencies in community care around the country. Stories were recounted of heroic efforts by existing community care services to deal with all the various needs of older people living at home. When the term 'innovation' was used to describe the origins of healthy ageing projects and services, many people felt aggrieved, mainly because they felt that it was impossible to discuss innovation in healthy ageing while core community care services continued to be underfunded. Stakeholders want basic community care services to be provided first, because it is through these services that healthy ageing advice and information is transmitted to the population. Participants from a variety of sectors proposed that the development of comprehensive public health nursing services, home help services, extended and flexible day care services and community-based social workers would substantially support the development of healthy ageing in Ireland. When these services are absent any innovation in healthy ageing carries a particularly high opportunity cost in terms of benefits foregone. At present, groups felt that day care provides most of the existing opportunities for healthy ageing projects and services in the community. Whether this is true remains an empirical question, but groups felt that day care is currently the most important element of community-based strategies for healthy ageing across the country.

3.2.3 Physical Environment

The physical environment, particularly housing for older people, was seen as a current priority and was generally ranked second by participants. Examples of types of housing initiative, both social and sheltered, were given at each of the seminars and significant progress is being made in this important area according to

participants. There were, however, three caveats raised at the seminars with respect to housing. The first is that progress must be accelerated to meet existing need given the poor condition of much of the existing housing stock for older people, particularly in rural areas. The second is the problem of maintenance for sheltered housing, with concern expressed at the poor record of some schemes in this regard. The third is the absence of policy integration between housing provision and social care provision for older people. Participants were acutely aware of a lack of coordination between health boards and local authorities in relation to the housing needs of older people at regional level. Other aspects of the physical environment mentioned in the seminars include transport initiatives for older people particularly in the north-west and north-east, and security and safety projects particularly in the south-east and in the south.

3.2.4 Social Integration

Projects dealing with the social environment for older people were generally ranked third in terms of current priorities by participants in the seminars. Within the social environment field, participants highlighted the work of the voluntary sector and community groups in developing social projects for older people that seek to increase the participation of the latter in social and community life. ARAs are very often the visible face of healthy ageing in local communities. In the north-east, for example, social interaction/integration was identified as a current priority by four of the six groups at the seminar. This is not surprising given the prominence of some ARAs in the North Eastern Health Board region. A recurrent theme in each of the regional seminars, was the acceptability of different options for social interaction offered by community groups and health boards. A strong preference was expressed for the development of more community-based social activities that are participative and led by older people themselves. Participants considered that opportunities for social interaction based solely in health board-run facilities were not essentially health promoting, primarily because the emphasis in these settings was placed on older people in terms of their care needs. Participants expressed the opinion that the most positive images of older people in Ireland were provided within the community/voluntary sector, providing better opportunities for the true voice of older people to be heard.

3.2.5 Other Projects

Not surprisingly, a wide range of other projects and services were listed under the current priorities heading, reflecting the variety of interests represented at the seminars. The Go for Life programme run by Age and Opportunity was seen

as important in almost all of the regions. Developments in psychiatry of old age were highlighted in the Midland and Mid-Western regions. Support services for carers were mentioned in the Eastern, North Eastern, South Eastern and Western regions. Personal and creative development projects, particularly in the Arts, were highlighted by groups in the Midland and Western regions as being important components of healthy ageing activities in these areas.

3.3 Future Priorities in Healthy Ageing: Stakeholder Views

3.3.1 Challenging Ageism

Participants from a range of sectors felt that challenging attitudes to ageing across society was the most important priority for the future. At each of the regional seminars, the view was expressed that older people are being discriminated against, not always consciously, due to an ageist culture that undermines their continued contribution to society and ultimately their citizenship. The retirement issue was raised at the seminars with many participants expressing frustration that withdrawal from economic life has been wrongly taken as a signal of withdrawal from community and social activities, leading to the downgrading of older people in civil society. The majority of participants felt that this was a problem that had to be tackled at national and regional levels. Participants favoured a national advertising campaign to remind people that life is not a series of points but a continuum, along which ageing brings new experiences that enhance the sovereignty and citizenship of older people rather than diminish them. People need to be encouraged to look at their life as a whole, over the life-course, rather than always simply dealing in the present.

Many participants felt that an important first step in dealing with ageism would be to stop using age as an institutional regulator for retirement from paid work and access to public pensions and services. This would be an important signal that people's age does not constitute a barrier to participation in economic, social and cultural life as they grow older. Participants argued for more flexibility in respect of retirement decisions and for greater opportunities for older people to remain involved in economic and social life if this is what they want to do.

Seminar participants from the voluntary and community sectors were particularly conscious of institutional ageism at work in the health and social services sectors. There was particular criticism of the health boards for contributing to a 'them (older

people) and us (public servants)' culture in the formulation and implementation of policies for older people in the regions. Many participants were of the view that older people are ignored by health boards in relation to the decision-making process. Participants were eager to see the involvement of older people in the planning and assessment of services and initiatives.

3.3.2 Holistic Models of Ageing

Participants at all of the seminars agreed that a major priority for the future should be the development of an integrated holistic model of ageing. Participants considered that strategies for healthy ageing should be broad enough to cover the wider aspects of ageing, incorporating a holistic view of the needs and preferences of older people at all levels of disability and transcending current preoccupations with healthcare needs. Participants proposed that the healthy ageing agenda extended beyond healthcare budgets, and that strategies and programmes should be in place to respond to the medical, psychological, emotional, economic and social needs of the older person. They also felt that interventions should be targeted to specific needs, and, where possible, specified standards and written protocols should accompany service plans to guarantee comprehensive provision of services.

A common theme expressed in the seminars, and related to the holistic argument developed above, is the need to prioritise the development of integrated community care services for vulnerable older people. At a macro level, people felt that there should be a reorientation from secondary/acute care to primary/community care, and this should be reflected in resource allocation and legislation regarding entitlements. Participants were impatient at the rate of progress towards a new primary care model in the community. At a micro level, stakeholders wanted more emphasis on health promotion within community care, with greater partnership between community care providers and health promotion departments. Many participants felt that older people should be free to choose the community care service that best fits their needs at a particular time. The experience of current community care services for older people described at the regional seminars was that of over-worked and restricted community-based nursing services and basic home help provision. People need many more services, more choices and greater flexibility if they are to continue to live at home when they become dependent. Health promotion and the development of healthy ageing strategies are central to this new model.

3.3.3 Housing

The issue of appropriate housing for older people featured strongly in discussions at each of the regional seminars, particularly in relation to the negative effect that inadequate housing options have on older people with a disability. Participants considered that suitable community-based accommodation for more dependent older people was under-provided in Ireland, despite some innovation in recent years with regard to sheltered housing in some regions. The need for life-time adaptable housing, particularly for people with dementia, was raised at a number of seminars. Participants were aware of a lack of partnership working between health boards and local authorities in relation to solving housing problems for older people. There was anger and frustration that coordination problems with respect to housing provision and finance continued to undermine the ability of older people to remain in their own communities. People felt that barrier-free housing was a basic human right that was routinely being denied to older people in this country.

3.3.4 Day Services

There was consensus that the ability of an older person to remain at home can be enhanced by the availability of various types of day service. There was a strong demand in the seminars for increased investment in day care facilities. Participants described a lack of integration between the operation of day services and general practice, and proposed that joint planning between primary care services and day services would ensure day services were used in an optimal way. Participants identified the need for greater flexibility in relation to opening hours, the need for individualised care, especially for people with dementia, and the need for coherent transport policies for day services. These issues have also been recently examined in the Council report *The Role and Future Development of Day Services for Older People in Ireland* (Haslett, 2003). Joint planning and cooperation between health authorities, transport authorities and voluntary agencies was proposed as a key area for future development in relation to healthy ageing.

3.3.5 Process and Quality of Life in Residential Care

Participants were also concerned about the quality of care within residential care settings. In particular, people were of the view that healthy ageing becomes more not less important when older people are admitted to long-stay care. There was concern that process issues within long-stay care settings were not currently accorded high priority. Participants felt that older people required more therapeutic-based services in long-stay care, including occupational therapy, physical therapy,

physiotherapy and diversional therapy, together with personal and creative programmes designed to stimulate mind and body. Participants expressed concern that older people are perceived by policy-makers as being passive consumers of care. The development of person-centred care that nurtures and respects the autonomy and dignity of the older person was seen as a critical ingredient of healthy ageing in residential care. Participants in the seminars also highlighted the need for a comprehensive training strategy for all staff working with older people in long-stay care that focuses on the needs of older people as human beings rather than as patients.

3.3.6 Social and Economic Functioning

The importance of social integration and intergenerational solidarity to healthy ageing was highlighted by several workshop groups at the regional seminars. The issue of adequate economic resources was also raised. It was clear from the seminars that participants recognised communication, participation and shared citizenship as the key elements of the social integration of older people in civil society. Participants felt that much more needed to be done to facilitate and encourage these important connections. There was a strong view that it was only through interdependence and solidarity that societies and communities prosper through the creation of valuable and sustainable social capital[5]. There was a somewhat resigned pessimism that the economy and economic relationships had replaced society and community relationships as the basis for human interaction.

Discussions on the impact of income on the health and well-being of older people considered that while there were very few older people who are absolutely deprived, the majority of older people were indeed constrained in their ability to participate in economic and social life because of lack of money. Participants felt that older people should receive higher levels of public pensions than at present and that annual changes in pensions should be linked to trends in average earnings rather than to inflation. Older women living on their own were highlighted as a particularly vulnerable group in society. In three of the eight seminars, participants recounted harrowing stories of particularly acute levels of poverty observed in this category. The view was also expressed that there should be more imaginative schemes available, both public and private, to allow older people to take advantage of the potential income streams to be realised from the value of their housing asset. The money currently tied up in assets, if released, could be particularly useful in facilitating higher levels of consumption by older people and in contributing to the cost of residential care for people in need of such care.

5 Social capital can be defined as the resources and capacity available to individuals and groups through their social connections to communities. It is an important ingredient for successful ageing, with older people represented on both the supply and demand sides of social capital within the community.

3.3.7 Other Priorities

There were, of course, many more suggestions emanating from the seminars on priority areas for the future, far too numerous to mention all of them in this Report. However, the following is an indication of the range of future potential priorities raised. The need for more retirement planning programmes was highlighted in the South Eastern and Southern Health Board regions. Participants in the midlands and the east were concerned about the need for more investment in dementia-specific community services and appropriate long-stay units for people with dementia. Investment in primary care was seen as a priority in the mid-west. The need for further initiatives in the area of rural transport was articulated in the north-west, south-east and south in particular. The potential of outreach programmes to combat isolation and loneliness was also highlighted in these two regions. Support for more healthy ageing activities for carers was a feature of the discussion in nearly all of the regional seminars. Breast cancer screening for older women was highlighted at the eastern seminar, along with the need for programmes aimed specifically at older men's health.

3.4 Issues in the Planning, Development and Operation of Healthy Ageing Projects: Stakeholder Views

3.4.1 Project Planning

Stakeholders raised a number of issues under the heading of project planning (see Table 3.1). A major problem for groups working in the field of healthy ageing is the absence of formal needs assessment data for planning purposes. There is no consistent approach to needs assessment and no official guidelines on how to assess population need across the full range of healthy ageing indicators. When needs assessment is carried out, it is often done at a local level without expertise and without financial support from the public sector. The absence of comprehensive needs assessment data makes planning very difficult and can lead to irrational resource allocation decision-making.

If, as most participants in the seminars agreed, a service-based model prevails then needs assessment becomes even more important for groups engaged in activities outside of core health areas. It may be particularly difficult for new projects to receive any, or consistent, funding, particularly if they are outside of

mainstream health areas. The absence of a culture of needs assessment in relation to the needs and preferences of older people was of concern to many participants at the regional seminars. Participants considered that resources were not allocated on the basis of need and that this was to the detriment of older people. It was viewed that the absence of needs-assessment information relating to older people perpetuated top-down decision-making that meant policies and programmes were not rooted in the true needs and preferences of older service users. Voluntary and community groups expressed particular concern about being marginalised from the policy-making process in relation to older people.

3.4.2 Funding

Not surprisingly, inadequate funding for the development of healthy ageing projects is also seen as a major issue. Participants were particularly sceptical of the commitment to funding community-based healthy ageing projects. They complained about the hospital and institutional bias of much of existing spending on older people and the difficulty of persuading policy-makers of the broader well-being gains associated with spending outside acute and residential care settings. The absence of transparency in relation to funding was also an issue for some people. There is no overall budget for healthy ageing, either nationally or within the regions. It is, for example, impossible to examine trends in overall spending, or in the composition of spending in the field of healthy ageing. Participants were generally in agreement that the National Cardiovascular Strategy is an important source of funding for healthy ageing activities and has been the mainstay of recent positive developments in this area. Some people expressed the concern, however, that many good projects had been 'crowded out' because they did not fit within the cardiovascular rubric. The need for long-term funding, on a multi-annual basis, was also highlighted as a particular aspect of the funding problem requiring attention. Voluntary groups highlighted the perilous nature of much of their funding which made planning much more difficult than it ought to be. Overall, planning is difficult when the funding mechanisms are *ad hoc*, fragmented and arbitrary.

Strategies that could be employed to strengthen community action in relation to the operation of healthy ageing initiatives were discussed at the regional seminars. Concern was expressed that many local communities do not get beyond the general recognition of problems, and, even when they do, their response is often too isolated, too narrowly focused, too poorly funded, with poor internal links within the community they wish to serve, and no links to outside communities or agencies. The desire to effect change is often present in local communities, but the skills, expertise, information and social networks necessary to transform the

lives of older people are underdeveloped. The importance of social capital as the catalyst for local community engagement in healthy ageing activities was mentioned at a number of seminars. We do not know anything about the nature and extent of social capital as a factor in the development of healthy ageing activities in Ireland. The declining rates of volunteerism were a cause for concern in relation to the social capital necessary to initiate and maintain community-based approaches to healthy ageing. The participants suggested that the absence of a comprehensive and consistent public policy for the creation of social entrepreneurs, the lack of an institutional framework to support and integrate them, and a poor general understanding of the concept of social capital and its importance to the health and well-being of older people in particular, were to blame.

3.4.3 Implementation

In terms of the ongoing development of projects, the absence of partnership models for public, private and voluntary cooperation was seen as a major issue. Many of the integration problems stem from the fact that healthy ageing tends to cross traditional, functional and administrative boundaries and is not comprehensively dealt with by any one statutory body. Community groups trying to embrace a holistic model have to deal with a myriad of organisations: the health boards, the local authorities, county councils, FÁS, the Department of Social, Community and Family Affairs, the Department of the Environment and many more. For the majority of community groups, the process of generating support and resources for healthy ageing projects is enormously time-consuming. Health boards, in particular, rarely respond in a formal manner to the needs of community groups and do not avail of their first-hand knowledge and understanding of social need at the local level. The lack of support structures is, therefore, exacerbated by the absence of dialogue between the statutory and voluntary/community groups representing older people. Representatives of older people's groups complained about not being listened to by the statutory agencies. Consequently, they felt that they were outside the policy process. New structures were demanded at the seminars whereby the community sector can formally engage statutory bodies as an equal partner in both the formulation of healthy ageing policy and in the delivery of locally-based healthy ageing projects and services.

Another major issue mentioned in the seminars was the difficulty of persuading older people of the benefits of healthy ageing activities. Men were particularly difficult to attract into healthy ageing projects and activities. For some participants, the absence of men from existing projects and services raised questions about the appropriateness of the majority of current schemes for men and the failure to

develop gender-specific projects that reflected the particular challenges men experience as they grow older. Some concern was expressed that existing projects and services tended to exacerbate inequalities in health and well-being in older people, as more vulnerable older people were often excluded, perhaps involuntarily, from existing activities. Inclusion takes time and resources, of course, but the view was expressed in more than one seminar that not enough is being done to make existing programmes inclusive for all categories of older people, l*et al*one develop new programmes specifically for excluded groups such as isolated rural men, disadvantaged older women living alone, older Travellers and so on.

Table 3.1: Issues in the planning, development and operation of healthy ageing projects

Project planning	■ No culture of needs assessment at health board level ■ Inconsistent approaches to needs assessment ■ No official guidelines ■ Inadequate expertise ■ Inadequate financial resources ■ Inadequate consultation ■ No partnership models ■ Irrational resource allocation due to needs assessment ■ Hospital and institutional bias
Funding	■ No ear-marked monies for healthy ageing projects ■ No national fund ■ No multi-annual funding
Implementation	■ Too many small pilot projects ■ Too little partnership ■ Inadequate structures for intersectoral discussion ■ Ageism and negative attitudes to older people ■ Too much health promotion for healthy older people ■ Not enough training in health promotion for health professionals

3.5 Best Practice in Healthy Ageing

3.5.1 Consultation

Consultation with older people was considered by seminar participants to be the most essential element of best practice. The strongly held view was that older people should be involved in a project from the planning stage through to the evaluation of outcomes. Projects should, where possible, lead to empowerment and autonomy for older people. There was criticism at the seminars that the structures necessary to allow meaningful consultation are not always in place. While there was strong condemnation at the seminars of health boards for not developing consultative structures, the view was also expressed that older people need to become better organised themselves if they want to be a major force in policy formulation. Representation for older people in this country is fragmented, which makes it more difficult for their voices to be heard in the policy process. One practical and immediate way of involving older people early in policy design would be to have them conduct the needs analysis upon which policy could be based subsequently. While people would have to be trained to conduct needs analysis, it would be appropriate to have the analysis carried out by those with first hand knowledge of ageing issues.

3.5.2 Sustainability

Continuity and sustainability were also mentioned as central to best practice and were linked to both funding and information-sharing at local, regional and national levels. People were critical of the uncertainty surrounding many projects and services in the field of healthy ageing. Funding tends to be short-term which, in turn, has an impact on long-term planning. Seminar participants working on healthy ageing projects were certain of their budgets for only one year at a time and many of them were working on short-term contracts. They worried about the renewal of their project every year and some projects had to generate their own funding in order to continue. This process has a dampening effect on staff morale and, of course, makes any sort of long-term planning impossible. People wanted multi-annual funding and to be involved in the ongoing assessment of their project with a view to achieving maximum effectiveness for the given budget. There were complaints at the seminars that decisions on funding were made arbitrarily, without transparency, and, in the case of termination, with little concern for the needs of staff and participants.

3.5.3 Information Dissemination

Information was seen as central to best practice by seminar participants. Currently, there is a dearth of information on needs, process and outcomes. While we have already discussed need assessment, there is an equal amount of ignorance on process, on how best to influence and encourage people to engage in healthy ageing activities. Participants in the seminars did not know what was going on in their own region let alone what was going on in other regions. This means that good practice is not being consistently replicated because people do not know of its existence or of its constituent parts. Conversely, bad practice can remain hidden indefinitely because of the absence of information and the weakness of dissemination flows. Not surprisingly, there were strong demands for better and more sustained information flows at the seminars. People complained that health boards spend too much time collecting routinely uninteresting information while, at the same time, failing to be proactive in generating data that might be useful to groups engaged in healthy ageing projects and services. Participants wanted more information on good and bad practice in the field of healthy ageing. There was also a call for the publication of common standards with respect to the provision of health board services for older people, which people saw as varying widely across the country.

Participants felt that there were a number of important points that could be made in respect of the most important influences on quality of life and well-being:

- health, measured both subjectively and objectively, strongly influences the well-being of older people
- physical functioning matters for quality of life
- psychological factors, such as personality factors, loneliness and feelings of powerlessness, influence well-being
- an accessible home and community environment has a positive influence on quality of life
- social factors matter with social isolation having a negative effect on quality of life
- self-respect and dignity are important elements in everyone's life, irrespective of age
- economic deprivation seriously damages the life chances and quality of life of individuals.

Each of these elements is amenable to intervention and preventative measures to a greater or lesser degree. There was a general view that healthy ageing projects and services should facilitate the identification and elimination of factors that undermine capabilities and performance in all aspects of life. This would be a major step towards enhancing the well-being and quality of life of dependent older people. In terms of good practice, this means a multifaceted, multidisciplinary, holistic approach that focuses on the whole life of the individual and directly involves them in the planning and implementation of care and support strategies.

3.6 Conclusions

One of the most recurring themes of the seminars was the prevalence of ageist attitudes in Ireland. People felt that multisector and interdisciplinary progress in healthy ageing was being impeded by the presence of an ageist culture in Irish society. The age of an individual is too often used as a proxy for determining a person's capability, flexibility, health and their ability to adapt to new situations, all of which are assumed to decline as a person approaches older age. Ageist attitudes, based on a link between age and competency, although widespread, are not inevitable or immutable and can be influenced by public policy. Such attitudes are socially conditioned and not a natural consequence of the ageing process. Ageism can and should be challenged. Participants wanted action to combat ageism at national, regional and local levels.

Participants were also aware of the multi-dimensional aspects of healthy ageing and the focus in all of the seminars was on the development of an integrated holistic model of ageing. Although many health issues were raised during the seminars and important points were made in respect of access to community care and appropriate residential care, people were conscious of the bigger picture, especially the need to look beyond bio-medical interpretations of well-being. There was, for example, an understanding of the importance of intergenerational relationships and solidarity between the generations for successful healthy ageing. Housing and transport were also seen as important elements of healthy ageing for older people. In terms of the development of healthy ageing projects participants were particularly concerned about the lack of funding to support innovation and best practice in the formulation and implementation of projects. Participants had equally strong views about best practice citing consultation, empowerment, continuity, sustainability and information-sharing, as critical elements of best practice in healthy ageing.

Chapter Four

An Analysis of Healthy Ageing Projects in Ireland

Chapter Four

An Analysis of Healthy Ageing Projects in Ireland

4.1 Introduction

This chapter provides an analysis of healthy ageing projects in Ireland based on the returns from the postal questionnaire described in Chapter Two. From the 1,400 questionnaires sent out, 318 replies were returned. Those who did respond to the questionnaire did so almost immediately and most of the returns occurred within the first month of the data collection process.

Of the 318 questionnaires received, most respondents adequately addressed the questions in relation to their own projects. There were some exceptions to this with the questions on funding, number of participants in the project and staffing levels all receiving lower response rates. However, most difficulty appeared to occur in Section B where respondents were asked to think about policy questions, some of which received very low response rates. While most people seemed able and confident enough to discuss their own project, many were unable or unwilling to address the wider issues of healthy ageing, especially those in relation to setting priorities for healthy ageing projects and services. On the other hand, respondents were quite willing to address issues of best practice, with nearly all respondents answering this open-ended question, some at great length. The response to best practice is considered in Chapter Five.

4.2 Analysis of Projects

4.2.1 Categorisation of Projects

Healthy ageing projects for older people are grouped into the broad categories listed in Table 4.1. The categories selected were those used in the *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998). The questionnaire invited respondents to state which of the five listed categories best fitted their particular project. 304 (96 per cent) of the questionnaires received addressed this question. The total number of responses (389) in this regard is greater than the number of questionnaires received because a number of respondents (63) replied that their project fell into more than one category. As can be seen from Table 4.1, the most common category was that concerning the social environment of older people, with 45 per cent of all projects fitting into this category. Categories relating to behaviour and lifestyle, and physical environment of older people were also important, with 20 per cent and 17 per cent, respectively of projects belonging to these particular categories. Projects concerned with specific diseases, accidents and suicides were less common.

The relatively poor return from healthy ageing projects in the specific disease category, at just nine per cent of all projects, requires explanation given the stakeholders views, expressed in Chapter Three, that most healthy ageing activities were likely to be found in this category. It may be that stakeholders are correct in their view that most of the resources are going into disease-related projects but that the health promotion and disease prevention elements of these projects are small relative to their curative dimension. Therefore, they do not show up as healthy ageing projects because the primary focus is on medical intervention. It may also be the case that people working in the specific disease category do not identify the work that they do as contributing to healthy ageing, even though it demonstrably does lead to improvements in length of life and quality of life for older people. This perception may be caused by a false dichotomy between two fundamentally different concepts of health – the psychosocial model which defines successful ageing in terms of well-being and social engagement, and the medical model which considers successful ageing in terms of disease and functional ability.

Table 4.1: Categorisation of projects

Categorisation	Frequency	%
Social environment of older people including social interaction, public attitudes, retirement issues and income support	176	45
Behaviour and lifestyle including physical activity, smoking, drinking, nutrition and diet	77	20
Physical environment of older people including housing, transport, security and the threat of violence and abuse	66	17
Specific diseases including heart disease, cancer, mental disorders, diabetes, arthritis etc.	37	9
Accidents and suicides among older people	22	6
Other	11	3
Total	**389**	**100**

4.2.2 Setting of the Project

Table 4.2 provides information on the settings of the projects. Here again, the total number of responses is substantially greater than the number of questionnaires received, the reason being that a large number of projects take place in multiple settings. The concept of a settings approach to health promotion was consolidated by the Ottawa Charter (WHO, 1986) which states that 'health is created and lived by people within the settings of everyday life: where they learn, work, play and love'. Currently, most health promotion is happening in the community: in active retirement groups and older people's own homes, followed by community-based services. From the questionnaires received, there appears to be a lack of healthy ageing projects in some of the more medical areas including the general practice/health centre, private and voluntary nursing homes, acute hospital and outpatients departments, which provide the setting for only 11 per cent of the projects involved.

The fact that there are relatively few projects promoting the health of older people in primary care settings is noteworthy, given the importance of the GP to the health and well-being of older Irish people (DoH, 1988; Brenner and Shelley, 1998; Garavan *et al.,* 2001) and an issue that requires further investigation. An alternative consultation process with GPs should be considered to investigate in-depth the

opportunities and challenges effecting the preventive care of older people and healthy ageing in general practice. For example, barriers identified in terms of vaccinating older people for influenza have been researched and would include the low level of reimbursement to GPs for the vaccination of eligible patients and the lack of proper systems to identify and contact those who should be getting the vaccine (Bedford *et al.*, 1997).

The promotion of healthy ageing is dependent to a considerable degree on policy and practice in primary care. Screening/assessment policies for older people in primary care seem to be considerably more *ad hoc* in Ireland than in the UK. The NHS offers a standardised assessment to all older people at age 75 (Idris Williams and Wallace, 1993) and a single assessment process for older people has now been developed as part of the NSF (DoH, 2001). However, in Ireland at present, assessment of older people in primary care is generally reactive, rather than proactive (NCAOP, 2002).

There is also some lack of clarity among older people (who, since 2001, are entitled to the medical card at age 70) in relation to the extent of medical card cover for preventative and screening procedures. For example, current practice in relation to medical card cover for the medical examination required for the renewal of driving licences after age 70 seems to vary between practices.

Consideration should therefore be given to developing the capacity of GPs and primary care teams to initiate and contribute to healthy ageing projects and services, for example, in relation to falls prevention and specialist healthy ageing clinics. Such a consideration could also address the barriers to the development of healthy ageing, including the concerns raised in relation to the operation of the medical card scheme for over 70's.

The poor representation of projects in the housing and transport sectors is also interesting given the importance of both sectors in the lives of older people. Both housing and transport were highlighted in the seminars as being priorities for future development in respect of healthy ageing. Housing is important because of the role it plays in keeping older people living in the community and out of long-stay care. Transport provides opportunities for social interaction and widens the choice set for older people, particularly for people living in rural areas. The small number of projects responding to the survey points to the need for a more coordinated approach in these two areas. Part of the problem may be that both transport and housing require more integrated development than has been possible up to now given the emphasis on healthcare services as the solution to all problems associated with healthy ageing.

Table 4.2: Setting of the project

Setting	Frequency	%
Day care/day centre	91	16
Active retirement group	86	15
Older person's own home	58	10
Health board long-stay care	57	10
Sports/recreation club	35	6
Respite care	27	5
Carers' group	26	4
Day hospital	26	4
Library	25	4
School	20	4
General practice/health centre	18	3
Voluntary nursing home	17	3
Workplace	16	3
Private nursing home	14	2
Acute hospital	12	2
Housing	12	2
Community setting	10	2
Transport	10	2
Outpatients	8	1
Other	13	2
Total	**581**	**100**

4.2.3 Status of the Project

Respondents to the questionnaire were asked to specify the current status of their project from the categories provided in Table 4.3. As expected the vast majority of respondents (81 per cent) replied that their project was up and running. Just over ten per cent replied that their project was in the planning stages. Two per cent were awaiting a decision on the renewal of the project, while three per cent of the projects will not be renewed. Of the 308 respondents, none of the projects had been cancelled.

Table 4.3: Current status of the project

Current status	Frequency	%
Up and running	250	81
Advanced planning stages	22	7
Early planning stages	12	4
Finished and will be renewed	9	3
Finished and will not be renewed	8	3
Finished and awaiting decision on renewal	6	2
Cancelled	0	0
Other	1	0
Total	**308**	**100**

4.2.4 Origins of the Project

Table 4.4 provides information on the origins of the projects. Almost seventy per cent of the projects came about because of an initiative taken by the organisation in question, either with or without a formal needs assessment, so healthy ageing is a distinctively bottom-up process. Fifty per cent of projects having their origins in the organisation had undertaken some type of needs assessment[6]. Twenty per cent of the projects originated within the health boards, again either with or without a formal assessment of needs. Only five per cent of projects had their origins in a local authority initiative. Overall, the projects were evenly divided between those where a formal needs analysis was completed prior to the commencement of the project (48 per cent) and those where no needs assessment was done (50 per cent).

6 Needs assessment refers to the process of finding out what people's needs are and what is the best response to meeting those needs and may be conducted through surveys, focus groups, listening days or public meetings.

Table 4.4: Origins of the project

Origins	Frequency	%
Initiative of your organisation but without formal assessment of needs	98	36
Needs assessment by your organisation	97	34
Health board initiative but without formal assessment of needs	31	11
Needs assessment by the health board	29	10
Local authority initiative but without formal assessment of needs	9	3
Needs assessment by local authority	5	2
Department of Health and Children national initiative but without formal assessment of needs	3	1
Needs assessment by the Department of Health and Children	2	1
Other	6	2
Total	**280**	**100**

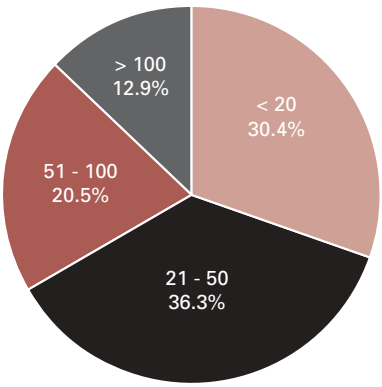
4.2.5 Partnerships and Links

Of the questionnaires returned that replied to the question on partners, 47 per cent indicated that they had partners, 45 per cent that they didn't have partners and the remaining 8 per cent didn't know (Figure 4.1). A similar response was provided to the question on links (are you linked to or networking with other healthy ageing projects, in addition to partners mention above) where 39 per cent of respondents reported having links with other healthy ageing projects, 48 per cent had no such links and the remainder did not know. The returns on partnerships and links is encouraging because it shows that projects are open to partnership, and are able and willing to forge links with each other. The development of the Healthy Ageing Database should facilitate even greater contact and increase the number and variety of links among projects.

4.2.6 Participants in the Project

The survey attempted to identify the number and characteristics of participants in healthy ageing projects. Figure 4.2 provides an overview of the proportion of older people participating in healthy ageing projects during a normal week. The scale of healthy ageing projects is small, mainly locally-based and linked to a particular community-based service. Of the 171 respondents that completed this section, 30 per cent replied that their projects had less than 20 participants per week, 36 per cent had between 21 and 50 participants per week, 21 per cent had between 51 and 100 older people per week, while 13 per cent had more than 100 participants in a average week. According to the 218 questionnaires that addressed the question on the gender of participants, there are significantly more females than males participating in healthy ageing projects. On average, 74 per cent of participants are female, with just 24 per cent of participants being male.

Figure 4.1: Number of people served by the project per week



4.2.7 Staffing Levels

Table 4.5 provides a breakdown on the number of people working full-time and part-time, paid and unpaid, on healthy ageing projects. The average mean number of people working full-time paid, part-time paid and full-time voluntary is relatively low with estimates of two, four and three respectively per project. Most of the workers work on a part-time voluntary basis. Two projects (Muintir na Tíre and the Irish Wheelchair Association) are excluded from the calculation of mean values because their inclusion significantly distorts upwards the mean averages for staffing levels, both paid and unpaid. The inclusion of median values reduces staffing averages across all headings. The number of respondents to most of the questions on staffing levels is relatively low, providing an indication that many people were not able to answer this question for their project. Therefore, some caution should be exercised when interpreting these results.

Table 4.5: Average staffing levels for projects

	Full-time paid	Part-time paid	Full-time voluntary	Part-time voluntary
Mean	2	4	3	13
Median	1	2	0	7
N	132	171	53	115

4.2.8 Project Evaluation

In response to the question on whether an evaluation was currently being done, 57 per cent of all respondents replied that an evaluation was currently underway, 18 per cent said no evaluation was occurring, while 25 per cent replied that they didn't know (Figure 4.3). The large numbers of 'don't knows' probably reflects confusion over what is meant by evaluation. That confusion is also likely to have affected the high number of positive responses to the evaluation question. It is unlikely that such a high level evaluation is taking place in over half of the projects in the Database. This is of concern because people may be confusing basic data collection and monitoring with evaluation. Issues of evaluation in healthy ageing are taken up again in subsequent chapters.

4.3 Issues in the Planning, Development and Operation of Healthy Ageing Projects and Services

Section B of the questionnaire asked a number of questions based on the respondent's experience of organising and running healthy ageing projects. A number of issues and challenges were listed (see Table 4.6) and respondents were asked to rank these in order of importance from 1 to 3. Column A in Table 4.6 reveals the percentage of respondents who felt that the listed reason was the most important issue in respect of planning, developing and operating a healthy ageing project. Column B indicates the percentage of respondents who felt that the particular reason was the second most important challenge and Column C reveals the percentage of respondents who felt that the issue was the third most important challenge. The final column shows the aggregate percentage of people who ranked the issues either first, second or third.

Almost twenty per cent of respondents felt that inadequate funding is the main challenge faced in project development. This matches the views from the seminars on the importance of funding. Similarly, reflecting the views from the seminars, thirteen per cent thought that the main issue was the prevalence of ageist attitudes in society. This result is interesting because it demonstrates that resistance to projects and problems in the operation and development of projects is affected by attitudes and beliefs within society. The lack of interest in healthy ageing among policy-makers and the absence of an integrated holistic approach to healthy ageing and well-being were also regarded as important.

Table 4.6: Issues in the planning, operation and development of healthy ageing projects: survey findings

Issues	A Rank 1 %	B Rank 2 %	C Rank 3 %	Total %
Inadequate funding for the development of projects	19	21	16	19
The prevalence of ageist attitudes in society	13	9	0	8
The lack of interest in healthy ageing among policy-makers	12	12	11	12
The absence of an integrated holistic approach to healthy ageing and well-being	12	6	9	9
The absence of qualified people to design and lead projects	9	5	11	8
The difficulty of persuading older people of the benefits of healthy ageing activities	8	13	6	9
The failure to allocate dedicated staff time to healthy ageing projects and services	8	8	10	9
The absence of integration and collaboration among health professionals	7	7	6	7
The absence of partnership models for public, private and voluntary cooperation	5	9	14	9
The absence of needs assessment data	4	4	5	4
The absence of appropriate guidelines on best practice in health promotion	1	3	5	3
The absence of suitable training programmes for all staff involved in projects	1	3	7	3
Other	1	0	0	0
Total	**100**	**100**	**100**	**100**

4.3.1 Adequacy of Funding for Healthy Ageing Projects and Services

The questionnaire sought to determine if the respondents felt generally that funding for healthy ageing projects and services in their region was adequate. There was general agreement that funding was inadequate, with 75 per cent of respondents concurring (Table 4.7).

Table 4.7 Adequacy of funding: survey findings

Adequacy	Frequency	%
Yes	32	15
No	162	75
Don't know	23	10
Total	**217**	**100**

Of those who felt that funding was inadequate, a further question was asked regarding why they felt that this was the case. A list of possible reasons was provided (see Table 4.8). Again respondents were asked to rank these reasons from one to three. A significant proportion of respondents (28 per cent) felt that the reason funding was inadequate was because there are more pressing needs in other areas of the health service. These people were aware of the concept of opportunity cost and the fact that choices had sometimes to be made. A further thirty per cent felt that the primary reason for inadequate funding was that the benefits of healthy ageing projects and services are poorly understood by policy-makers. This points to inadequate information dissemination, which the development of the Healthy Ageing Database will assist in resolving. It is likely, however, that policy-makers would be further convinced by valid evaluation data showing the benefits of healthy ageing projects clearly. That older people are generally not seen as a deserving group in society and that the benefits of healthy ageing projects and services are poorly understood by many health and social care professionals were also regarded as important, with fifteen per cent and ten per cent respectively of respondents identifying these as the main reason for inadequate funding. Age discrimination is seen as important by seven per cent of respondents. Age discrimination may also be behind the thinking of some respondents who ranked 'older people are generally not seen as a deserving group in society' as number one.

Table 4.8: Reasons why funding is inadequate: survey findings

Reason	A Rank 1 %	B Rank 2 %	C Rank 3 %	Total %
The benefits of healthy ageing projects and services are poorly understood by many policy-makers	30	20	26	25
There are more pressing needs in other areas of the health service	28	14	10	18
Older people are generally not seen as a deserving group in society	15	13	14	14
The benefits of healthy ageing projects and services are poorly understood by many health and social care professionals	10	21	17	16
Age discrimination routinely informs resource allocation in health and social care	7	15	17	13
The benefits of healthy ageing projects are poorly presented by advocates	7	16	14	12
Other	3	1	2	2
Total	**100**	**100**	**100**	**100**

4.4 Priorities for Healthy Ageing Projects and Services: Stakeholder Views

4.4.1 Setting Priorities for Healthy Ageing Projects and Services

Table 4.9 reveals how people think that priorities for healthy ageing projects and services are currently set. Over half of all respondents to this question felt that priorities are determined from the top down by Government Departments, health boards or local authorities without consultation with older people or local communities. Just over a quarter of respondents felt that priorities are determined on an *ad hoc* basis by the relevant government, regional or statutory agencies. Just five per cent of respondents felt that older people themselves are actively involved in the priority setting process. This figure demonstrates how little older people are involved in policy formulation and how much work remains to be done to get them involved in a meaningful way. This issue is taken up again in Chapter Eight.

Table 4.9: Setting priorities: survey findings

How are priorities currently set	Frequency	%
Priorities are determined from the top down by Government Departments, health boards or local authorities without consultation with older people or local communities	121	51
Priorities are determined on an *ad hoc* basis by the relevant government, regional or statutory agencies	62	27
Priorities are determined from the bottom up by local and community-based interest groups working with older people	26	11
Priorities are determined on the basis of careful needs assessment of older people by the relevant government, regional or statutory agencies	12	5
Priorities are determined through extensive consultation by the relevant government, regional or statutory agencies with all interested parties, including older people	12	5
Other	3	1
Total	**236**	**100**

4.4.2 Future Priorities for Healthy Ageing Projects and Services

Respondents to the questionnaire were asked which three areas of activity of those listed in Table 4.10 (page 92) should receive additional resources/funding, if such funding was to become available for healthy ageing projects and services. The responses to this question were spread across all potential areas, probably reflecting the areas that the respondents are currently working in. However, as can be seen from the Table, increased funding for social interaction/integration and the promotion of better attitudes to old age and society are regarded as priority areas, with sixteen and twelve per cent respectively of respondents highlighting these two areas. Personal and creative development for older people, while not regarded as the main priority by many, was often seen as a secondary or third area for priority. Mental health promotion also scored highly as did stroke prevention.

Hearing and eyesight projects were accorded low priority by respondents. It is impossible to say conclusively why rankings are low for these two issues but this requires further examination. It would be a concern if respondents considered losses to vision and hearing to be natural consequences of ageing and therefore beyond the remit of healthy ageing interventions. Significant health and social gain is associated with healthy ageing interventions aimed at the prevention and screening of sensory impairment, as well as the development of enabling environments (Abutan, 1993; Mulrow, 1990). Research suggests that 25 per cent of blindness in Ireland is potentially avoidable (Munier, 1998) and 81 per cent of over 75's randomly selected from Irish GP lists had visual impairment but only 31 per cent of these problems were not known to the GP (Natin, 1999). This would suggest that the development of healthy ageing projects and services relating to sensory impairment should be fostered by health promotion departments. Similarly, there are likely to be significant gains from healthy ageing initiatives focussing on diabetes, and dental and oral health, subjects which were not prioritised by respondents. (Diabetes Service Development Group, 2002).

4.4.3 Future Priorities by Category of Older Person

Older people living alone are regarded as a priority group by many of the respondents, with nearly one in three replying that this is the category which should receive additional funding, if such funding were to become available. Homeless older people, older people in deprived economic circumstances and rural older people are also thought of as deserving groups, with 35 per cent of respondents indicating that these groups should receive priority (Table 4.11, page 93). Somewhat surprisingly, people with illness, whether physical or mental, were not regarded as high priority groups. This may reflect a feeling that these groups already receive a large amount of the

Table 4.10 Future priorities for healthy ageing projects and services: survey findings

Future priorities	A Rank 1 %	B Rank 2 %	C Rank 3 %	Total %
Social interaction and integration	16	9	11	12
Promotion of better attitudes to old age in society	12	11	12	11
Mental health promotion	8	6	7	7
Stroke prevention	8	4	4	5
Personal/creative development	7	14	11	11
Physical activity	5	7	4	5
Prevention of heart disease	5	4	1	4
Transport improvements	4	7	7	6
Housing improvements	4	3	5	4
Planning for retirement	4	3	2	3
Nutrition and diet	3	4	5	4
Health promotion for carers	3	3	5	4
Cancer projects	3	1	2	2
Suicide prevention	3	2	1	2
Security and safety	2	5	8	5
Accident prevention (falls, fire, road)	2	7	4	4
Abuse	2	1	2	2
Sensible drinking	2	2	1	2
Stopping smoking	2	0	0	1
Incontinence projects	1	2	2	2
Hearing and eyesight projects	1	1	2	1
Prevention of lung diseases/ breathing disorders	1	1	2	1
Diabetes projects	1	1	1	1
Foot disorder projects	1	1	1	1
Dental and oral projects	1	1	0	0
Sexuality for older people	0	0	0	0
Other	0	0	0	0
Total	**100**	**100**	**100**	**100**

resources earmarked for older people and that additional resources should be redirected towards other groups. Respondents may be making judgements on the marginal benefits associated with increased spending on different groups.

The priority groups for future development link very well with current epidemiological studies on who is most at risk of premature death. These include people on low income, people in sub-standard housing and homeless people. The main risk factors for placement in long-term care are also reflected in the Table, namely people living alone, those with low income, those living in poor housing and people with dementia. This reflects a deep understanding of the main determinants of health and well-being among respondents. This knowledge and understanding should be drawn upon much more by policy-makers in the form of greater consultation and partnership in both the planning and development of healthy ageing projects.

Table 4.11: Future priorities by category of older person

Future priorities	A Rank 1 %	B Rank 2 %	C Rank 3 %	Total %
Older people living alone	31	17	15	21
Homeless older people	15	9	9	11
Older people in deprived economic circumstances	10	14	20	15
Rural older people	10	11	12	11
Older people living in sub-standard accommodation	9	12	8	10
Older people with dementia	8	10	6	8
Older people with mental illness	4	6	7	6
Older people in public long-stay care	3	9	6	6
Older people with physical illness	3	4	6	4
Older people with low levels of literacy	2	2	5	3
Older people in private nursing homes	2	2	3	2
Visually impaired older people	1	2	2	2
Older people from an ethnic minority	1	1	1	1
Older prisoners	0	0	0	0
Other	1	1	0	0
Total	**100**	**100**	**100**	**100**

4.5 Conclusions

A number of conclusions can be drawn about healthy ageing projects operating in this country from the survey. Nearly half of all projects are concerned with the social environment of older people including social interaction, public attitudes, retirement issues and income support. Just over twenty per cent of projects occur in active retirement groups or sports/recreation clubs. Ten per cent of projects occur in older people's own homes. A further sixteen per cent occur in a day care/day centre setting. There appears to be a distinct lack of projects in general practice and acute care settings. The exception is the health board long-stay sector which supports ten per cent of projects.

Seven out of every ten projects came about because of an initiative taken by the organisation providing the service. This in-house innovation should be nurtured through appropriate national and regional support mechanisms and structures. Generally, projects are evenly divided between those where a needs analysis had been conducted and those where no such analysis took place. Projects are quite small in scale, with two thirds having less than fifty participants per week and a third having less than twenty. The ratio of female participants to male participants in healthy ageing projects is three to one. Projects are mainly staffed by part-time voluntary workers.

Inadequate funding and ageist attitudes are regarded as the main obstacles to the development of healthy ageing projects in this country. Three quarters of all respondents felt that funding for healthy ageing projects was inadequate and twelve per cent replied that additional funding should be used for the promotion of better attitudes to old age in society. Older people living alone and homeless older people are regarded as the most deserving groups for additional funding if such funding were to come on stream.

Chapter Five

Case Studies in Healthy Ageing

Chapter Five

Case Studies in Healthy Ageing

5.1 Introduction

We have selected ten projects from the Healthy Ageing Database to demonstrate the range and quality of work currently been undertaken in the healthy ageing field in Ireland. These projects were selected on the basis of two criteria. First, there is at least one project from each of the seven health boards areas and from the Eastern Regional Health Authority. Second, there is at least one project from the five areas listed for policy and action in *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998) having their origins in the Ottawa Charter.

The projects are not selected on the basis of any scientific criteria relating to best practice and, therefore, cannot be judged better or worse than projects not selected in that regard. Nevertheless, while the selection of these projects is opportunistic, each has important attributes which makes them interesting and worthwhile, and project leaders were asked to consider best practice issues when returning information on their project. In general, the purpose of the case studies is to show what can be achieved in various sectors and encourage the reader to enter the Healthy Ageing Database where there are many more interesting examples of projects in their own field.

The projects are arranged as follows in line with the framework provided by the Ottawa Charter:

1. Building healthy public policy
   - a Voice for Older People

2. Creating supportive environments
   - the Lawn Social Housing Scheme

3. Strengthening community action
   - the Senior Help Line
   - Go for Life

4. Developing personal skills
   - Wexford Libraries Reading Projects
   - Back to Education
   - West Cork Arts Centre

5. Reorienting health services
   - FORUM Social Care Project
   - the Midland Health Board Diabetes Shared Care Project in Primary Care
   - the Falls Prevention Programme

Each project is discussed under five headings as follows:

- description of project
- values and philosophy of the project
- outcomes
- best practice
- lessons from the project.

5.2 Building Healthy Public Policy

5.2.1 A Voice for Older People

5.2.1.1 Description of the Project

A Voice for Older People is a community development project operating in the North Western Health Board (NWHB) region, which explores and tackles health and social issues with older people. The project works through a capacity-building process involving communities, the service sector, voluntary providers and the private sector.

The objectives of the project are:

- to develop a representative and recognised forum of and for older people in Donegal with clearly identified roles
- to develop five geographically-based working groups with clearly identified roles
- to develop a community-based education strategy on issues relating to older people
- to develop an evaluation framework for these objectives, which can be used as a research action tool using the principles of community development.

Elected members from the evolving forum for older people have linked directly at policy-making level with bodies such as the Area Partnerships, Vocational Educational Committees, Community Forum and 'Choice' in the NWHB. Action on issues identified is taken in partnership with communities and service providers. For example, the identification of security and social isolation as a key issue of concern on feedback sheets from 290 older people who attended an open day organised by the local groups resulted in a feasibility study and subsequent application to develop a senior telephone link line in the area.

5.2.1.2 Values and Philosophy of the Project

The project seeks to reflect the diversity of older people. The influence of inequalities in later life in relation to access to resources such as income, health and services are challenged. A holistic and rights-based approach to promoting the quality of life and health of older people, led by older people themselves, lies at the core of the project. The project operates through partnerships built on respect, understanding, power-sharing and change.

In the planning phase of the project, older people identified the following key values:

- actions to be older person-led
- work of the group to be driven by older people
- individuals to have a right not to be involved
- to operate in a non-ageist and non-discriminatory fashion

- to have a positive focus on gender, where necessary
- decision-making to be by the majority
- awareness of intergenerational issues.

5.2.1.3 Outcomes of the Project

The project has had the following outcomes:

- improved well-being and quality of life of older people in the region
- increased participation of older people in social and artistic life
- reduced social isolation through participation at local and county group meetings, and senior telephone link line development
- increased information flows and communication
- increased skill development of older people to lobby, negotiate etc.
- recognition as a collective and representative voice in Donegal
- increased knowledge of ageism, and the development and implementation of actions to challenge discrimination e.g. mammography and actions taken to challenge policy
- increased self-esteem and confidence of members.

5.2.1.4 Best Practice

The project is based on real participation and the voice, empowerment and autonomy of older people are now seen as important. It has successfully engaged and influenced the agendas of agencies, such as the VEC and the Garda Síochána, to better meet the needs of older people. It has also changed the approach to planning in the region towards a more social model of health for older people. Needs assessment has continued throughout the project and evaluation is central, being built into the project since its inception.

5.2.1.5 Lessons from the Project

This project is owned and led by older people. It is on this basis that the threads of active community participation, partnership, equity and social justice are woven. The important lesson from the project is the importance of putting older people at the heart of the decision-making process (from planning, through practice, to evaluation) and the benefits to be gained by such a process.

5.3 Creating Supportive Environments

5.3.1 The Lawn Social Housing Scheme

5.3.1.1 Description of the Project

The Lawn is a twenty-five unit social housing scheme for older persons in Claremorris, Co. Mayo, developed by Clár Integrated Resource Development (IRD), a local voluntary community development organisation. The scheme comprises sixteen single-bed houses, seven two-bedroom houses, two apartments and a communal building, which currently house thirty residents, with a waiting list of more than thirty-five. The scheme was completed in November 1999 at a cost of £1.2 million. The houses have design features supportive of independent living and are spacious (650sq. ft for a single and 750sq. ft for a double). The layout includes an open-plan living area which is fully wheelchair accessible, and five residences with wheelchair accessible kitchens. The housing scheme is designed in two facing semi-circles conducive to social interaction, with the doors set back to provide each person with privacy. Each house is equipped with a private back entrance and garden.

The aim of the project is to provide high quality, affordable accommodation to older persons where they can live in security and have access to services in a community setting, where their previous accommodation failed to provide these elements.

5.3.1.2 Values and Philosophy of the Project

The project came about because of several attacks on older people in the surrounding areas in the mid-1990's. A needs assessment revealed that as well as the demand from rural older people for secure accommodation, there were a number of older people in the town who were also in need, due to a combination of poor living

conditions, lack of financial resources or difficulties with current accommodation due to failing mobility. Affordable housing provided in a safe and secure environment was the key principle underpinning the development of the project.

5.3.1.3 Outcomes of the Project

The project has had the following outcomes:

- improved accommodation for older persons from a safety, security and standard point of view
- a more comfortable living environment for older people which has a direct effect on their health and quality of life, by virtue of less damp and other structural problems associated with older houses
- an environment based on independence with no compulsory meetings or meals, with the majority of the residents cooking and cleaning for themselves on a daily basis
- a communal area for social activities for residents and friends, with events including coffee mornings, holiday lunches, yoga, outings, and information talks on various topics, such as community welfare.

5.3.1.4 Best Practice

The Lawn is a model of best practice primarily because of its commitment to consultation with residents. Meetings are held between the residents and the manager and administrator bi-monthly. An example of action arising from these meetings was the provision of a post-box at the entrance to The Lawn, as the majority of the residents communicate with friends and family by post and the post office is some distance away.

The Lawn also emphasises participation. For example, residents manage and plant their own communal gardens, which encourages a more active lifestyle and social contact. The gardens won second place in the tidy estate competition run by the local authority – an example of how the scheme remains part of the local community.

FÁS-sponsored schemes have been of benefit to both the residents and the employees. An administrator employed under the Jobs Initiative Scheme has benefited so much from her position that she will be starting a course in social

care in NUIG in 2003. The employment of two men under the FÁS Social Economy Programme provides low cost maintenance for the residents who, otherwise, would have to pay full call-out charges for something as simple as the fitting of a washer. The scheme is part-financed by the rental income so, unlike FÁS CE Schemes, it is not totally dependent on Government funding.

5.3.1.5 Lessons from the Project

The lack of stable long-term funding for management and maintenance for the Lawn threatens the environment created there, as the Social Economy Programme is only guaranteed for three years. There is no secure funding mechanism, yet if the residents were to go into a nursing home they would be entitled to a subvention. A fraction of the cost of the subvention scheme would allow schemes to employ full-time staff and cease dependence on FÁS schemes, home helps and other schemes, the application of which is very time-consuming.

Training for management committees in negotiating with older persons would be of benefit as conflict does arise between paid staff, volunteers and the residents. Cutbacks in community care services, such as home helps, threatens the efficiency of housing schemes and the quality of life of the residents.

Clár IRD is currently at an advanced stage of planning for a thirty-two unit sheltered housing scheme that will incorporate the best features of The Lawn with the following improvements:

- a larger, more flexible communal area
- a nurse practitioner's room onsite
- no open fires and an energy efficient, low cost heating system
- a 24-hour warden service.

5.4.1 The Senior Help Line

5.4.1.1 Description of the Project

The Senior Help Line was established in 1998 by the Summerhill Active Retirement Group to provide a listening service for older people who are lonely and isolated. It began with the establishment of a small 'telecentre' at the Third Age Centre in Summerhill, Co. Meath, comprising three telephone-answering stations installed in a layout to ensure privacy for the caller. With the ongoing support of the health boards, the service has progressed from one centre at Summerhill to a national service, with approximately three hundred older people servicing the lines from centres in Ballincollig, Limerick, Cavan, Mullingar, Finglas, Tallaght, Sligo and Waterford. It is now available seven days a week with the number of calls steadily increasing.

The service is operated on a voluntary basis by older people who have attended a specially designed training programme. It is non-directive and confidential, and volunteers sign a pledge to that effect.

The primary aim of the Senior Help Line is to provide telephone support for socially excluded older people who call the line during the hours of operation.

5.4.1.2 Values and Philosophy of the Project

The availability of a friendly voice on the phone, for the price of a local call from anywhere in Ireland, is a welcome link to the outside world. When the voice is that of an older person, enriched with the experience of life, with sensitivity and caring, the callers have the opportunity to express, to a sympathetic listener, the fears and worry of their lives or just have a chat about life in general.

The Senior Help Line is a confidential service. Volunteers are forbidden to impose their own religious, political, philosophical or any other personal views on callers. The caller is free to break contact at any time. Where appropriate, callers are invited to consider seeking help from other agencies and the Senior Help Line operates in a complimentary way to the services of existing voluntary and statutory agencies. The service does not contact other agencies on behalf of callers. The greatest resource and asset for the Senior Help Line is the work of the older volunteers who give their time and energy to the planning, training and running of the service.

5.4.1.3 Outcomes of the Project

The project has had the following outcomes:

- the Help Line receives a large number of calls from older people. In particular older people contact the Help Line to share their personal experience of loneliness, for which the present service makes a valuable contribution
- both older men and women use the Senior Help Line
- the frequency and duration of calls and the willingness of the callers to talk about their problems indicates that older people are ideally suited to offer mutual support to other older people
- the service is also of benefit to the older volunteers who express great satisfaction with their work and benefit from the support that they receive from other members of the group. Older volunteers are highly dedicated and reliable
- the training programme that was organised prior to the launch of the Senior Help Line, in conjunction with the Samaritans, proved successful in preparing the volunteers for their work
- the cost of the project is low, because the volunteers provide their labour for free and because administration costs are low.

5.4.1.4 Best Practice

The Senior Help Line represents best practice primarily because it recognises the value of older volunteers and empowers older people, encouraging them to use their personal resources to support other older people. It is also an example of a successful partnership between voluntary groups, health boards, community enterprise, the Office of Health Gain (now defunct) and the Department of Health and Children. The coordination and integration of the operation of the Help Line with existing service providers also makes for good practice.

5.4.1.5 Lessons from the Project

The partnership ethos contributed to the success of the project. Support from the health boards, through the Health Boards Executive, greatly assists the growth and

development of the project. Securing appropriate funding for the initial development was challenging and additional funding will be required to support an expansion of the service.

The participation of older volunteers was critical to the success of the project. Empowerment is therefore a critical aspect of the Help Line. The increasing volume of calls and widening geographical spread suggest that administrative demands will become greater as the project becomes more extensive.

5.4.2 Go for Life

5.4.2.1 Description of the Project

Go for Life is the national programme for sport and physical activity for older people. It is an Age and Opportunity initiative grant-aided by the Irish Sports Council and guided by an umbrella Steering Committee with representation from older people's organisations and other interested groups.

Go for Life is implemented through the following programmes:

- the Active Living programme which aims to increase participation by older adults in health-enhancing physical activity and focuses on older adults who, though independent, are not engaged in physical activity on a regular basis
- the Sports Participation programme which aims to promote greater involvement by older people in organised recreational sports. focusing on older adults who regularly engage in physical activity and can be described as physically fit
- the National Grant Scheme which assists local clubs and organisations for older people to increase physical activity opportunities for their members
- the Physical Activity Awareness programme which aims to increase older people's awareness of the benefits of an active lifestyle and of the opportunities for involvement in active living and recreational sport.

The central aim of Go for Life is to involve more older adults in all aspects of sport and physical activity more often.

5.4.2.2 Values and Philosophy of the Project

Go for Life is based on a wealth of research which demonstrates the physical, psychological and social benefits of remaining physically active in older age. Go for Life is part of the broader work programme of Age and Opportunity, which challenges attitudes to ageing and promotes greater participation by older people in all aspects of society. It is informed by an ethos of the empowerment of older people, reflected in the workshops held to train older people to become Physical Activity Leaders (PALs), and ultimately to lead sport and physical activity programmes with their peers.

5.4.2.3 Outcomes of the Project

The project has had the following outcomes:

- increased awareness among older adults of the physical, psychological and social benefits of physical activity in later life
- increased levels of participation in health-enhancing physical activity and recreational sport by older adults and consequent physical, psychological and social benefits for individuals
- improved quality and quantity of physical activity and recreational sport opportunities for older people
- increased numbers of older people with the skills and confidence to be involved in voluntary peer leadership
- raised awareness of the physical activity/sports needs of older adults among those working in the leisure industry and in sport
- improved opportunities for older adults in leisure centres
- enhanced opportunities for the development of sport and physical activity among clubs and groups of older people.

5.4.2.4 Best Practice

The project can be considered as a model of good practice because it uses peer mentoring to empower older individuals to lead physical activities themselves.

It is also based on partnership. In the first instance, the Steering Committee comprises individuals representing national older peoples' organisations, the Irish Sports Council and key individuals with experience of physical activity and health. In addition, partnerships have been forged with health promotion departments and the network of Local Sports Partnerships, ensuring long-term sustainability.

The project seeks advice and guidance from a broad range of people with scientific and technical expertise, and external evaluation is a feature of the programme which informs programme development.

5.4.2.5 Lessons from the Project

Partnership has been the key to success for the Go for Life programme. The development of a national partnership project of this nature took time, but, through careful negotiation the programme was structured to accommodate the aspirations of a range of partners with different priorities. Implementation of the programme in conjunction with the health boards and sports partnerships has ensured national coverage.

One of the early challenges faced by the programme was that the health promotion departments were in the early stages of development in some health board regions (and non-existent, in others), and sports partnerships are still in the process of being established. Well-resourced health promotion departments and sports partnerships with a commitment to working with older people would assist the impact of the programme into the future.

A challenge for the programme, revealed in the evaluation of the first phase, is the difficulty of ensuring equity of access within the programme among all socio-economic groups and ensuring that leaders encourage physical activity among the more sedentary members of their clubs, day centres and ARAs.

5.5.1 Wexford Libraries Reading Projects

5.5.1.1 Description of the Projects

Stories from the Hearth

This storytelling programme has operated annually since 1999, with a learning focus every October/November and May. The programme has now extended into day care centres and two hospitals. Core performances have been supplemented with training in skills development and reminiscence work and also incorporate an intergenerational element.

About Books

This action research project commenced in 2001. It promotes critical reading and exposure to contemporary literature through the creation of five community reading circles based at County Wexford's public library network. Sixty participants meet monthly, discuss agreed texts and contribute to an 'About Books' column in a local newspaper (with a potential readership of 20,000). A season of Talking about Books programmes on a local radio station was also developed.

Thursday Club

The Thursday Club at Wexford Town Library is an open meeting occasion for older people that includes workshops and talks, reading-exchange and other weekly activities. Two formal and two informal activities are also organised each month. The Club was developed as a result of a recreational taster day provided by Age and Opportunity with the National Irish Bank in 2001, at which core members were identified. It has developed learning initiatives in information technology in partnership with the library service and the local VEC.

Reading Down the Ages

Reading Down the Ages is an active-reading, research project for older adults, some of whom have limited literacy, which is currently in operation. The project focuses on group listening and discussion of contemporary literature, with the starting point being people's schooldays experiences. A local writer working with library and healthcare staff facilitates the process. Six groups are established in libraries and day care centres, as well as one in a long-stay hospital, and these groups meet weekly or fortnightly.

5.5.1.2 Values and Philosophy of the Projects

The projects value the experience of older people and support the continuing contribution of older people to community development. They also acknowledge the entitlement of older people to personal development opportunities and encourage self-realisation. In addition, they seek to challenge community attitudes to ageing.

Library initiatives for group work with older people wherever possible are marked by intergenerational capacity, routes to self-sustainable learning, and reflective and echoing elements for participants.

5.5.1.3 Outcomes of the Projects

The project has had the following outcomes:

- creation of social networks among older people
- personal and creative development for older people
- older people within established groups are managing their projects to a significant degree, with the library now offering a less visible information-support role
- computer literacy skills and information handling skills have been imparted to participants of the Thursday Club.

5.5.1.4 Best Practice

The reading projects originated from the access level and interests of the participants and are increasingly driven by older people themselves. This makes the projects more sustainable and empowering.

Partnerships with the local VEC, FÁS, the local newspaper, Age and Opportunity, and the South Eastern Health Board have proven fruitful. The projects have acted as safe gateways into more extensive community involvement for some older people.

The projects have also been cost-effective in their delivery by utilising existing resources available in all modern public libraries e.g. multiple audience books and other learning materials, computer facilities, staff expertise and free accommodation. Similar infrastructure exists and could be exploited countrywide.

5.5.1.5 Lessons from the Projects

Careful planning, heavy investment at the pilot stage and flexibility have been the essential ingredients to the success of the projects. The projects benefited from introductory experimental periods, which was particularly important given the informal learning models utilised. In the absence of a visible outcome, the power of literature and reading can be difficult to sell to sectors not traditionally involved in formal education. Participating staff can feel vulnerable initially, and reassurances in relation to roles and expectations are essential.

The delivery of services to dispersed populations can challenge budgets and projects require significantly reduced but essential maintenance budgets beyond the establishment phase. The peripheral nature of this work to the many agencies involved poses difficulties for mainstreaming and sustainability.

5.5.2 Back to Education

5.5.2.1 Description of the Project

The Back to Education initiative is a partnership project between the Dean Maxwell Community Nursing Unit and North Tipperary VEC. The programme is funded through the Department of Education with National Development Funding. Tutors and raw materials are funded by the VEC and all of the classes (except for woodwork) take place in the Community Nursing Unit. Course choices available to older people in the Unit include cookery, beauty and grooming, woodwork, literacy skills and technology awareness. Groupwork and one-to-one expressive art classes are also offered.

The impact of the project can be seen by taking the example of the woodwork class. On Tuesday afternoons, twelve older people attend the local college where the tutor is assisted by three Transition Year students who also visit the Community Nursing Unit and are known to the residents. Participants have each made something functional, decorative and religious. The classes are informal, intergenerational and productive. The sense of achievement, creativity, renewal, participation and belonging is priceless. Working with wood has been an invigorating experience for the residents.

The overall aim of the project is to engage the older people in the Community Nursing Unit in a range of flexible learning opportunities.

5.5.2.2 Values and Philosophy of the Project

The project identifies the potential for life-long learning among older people at all levels of ability. Accessibility and inclusiveness are core values of the project and it aims to recognise and accommodate diversity in relation to the preferences of older people. The project is also based on local consultation and partnership, and includes an emphasis on quality assurance.

5.5.2.3 Outcomes of the Project

The project has had the following outcomes:

- positive and flexible learning experiences for older people in a Community Nursing Unit
- personal development for older people
- choice and autonomy for older people
- promotion of positive attitudes to older people in the wider community
- improved quality of life and well-being for residents.

5.5.2.4 Best Practice

This project includes equity as a core element of best practice. The development of opportunities for life-long learning among older people, particularly those with a disability, challenges the perception of older people solely in terms of their care needs in the setting of a Community Nursing Unit. The elements of choice and contact with other groups can be viewed as empowering.

5.5.2.5 Lessons from the Project

The main lesson from the project is that older people, in whatever setting, should have opportunities for life-long learning and education. Training and education opportunities should be appropriate and can be designed to suit the interests and needs of older people. An intergenerational dimension adds an extra quality to training and education. Involvement of older people in the decision-making process and regular consultation is required. Partnership is a key element in ensuring the success of projects in this field.

5.5.3 Older People's Programme

5.5.3.1 Description of the Project

The Older People's Programme at the West Cork Arts Centre involves a number of inter-linked projects operated in partnership with West Cork day care centres, West Cork ARAs, the Southern Health Board (SHB), and Age and Opportunity. A number of small pilot projects in dance, storytelling, visual art and drama have been implemented in hospitals, day care centres, community centres and at the Arts Centre itself. These projects pointed to the potential for the development of a longer-term sustainable Arts programme with older people. Emphasis has been placed on developing partnerships. Despite small budgets, each project managed to raise between €1,500 and €4,000 to cover artist's fees, materials and documentation. Other resources such as workspace, transport, professional support and administration, volunteer support and hospital/day care staff support were resourced through partnership practice.

The overall aim of the programme is to develop ways in which older people can have access to and can participate in the Arts.

5.5.3.2 Values and Philosophy of the Project

The core value of the programme is that access to the Arts is a democratic right. The Arts are seen as broad and multidimensional, involving and stimulating thought and planning, memory and personal expression. Communication is embedded in the programme exposing older participants to new forms of media, as well as meeting and working with artists. Although older people are not a homogenous group, there are specific issues (such as disability, prior access to education, vision and hearing etc.) that are taken into account when planning the programmes. There is a growing understanding by health agencies of the benefits of involvement by older people in Arts programmes for their health and well-being, which provides an opportunity for Arts programme development within health organisations.

5.5.3.3 Outcomes of the Project

The project has had the following outcomes:

- contributions to the well-being of participants
- stimulation of mind and body with a range of new and creative activities is life-enhancing, health-promoting and empowering

- different modes of cognition and communication are encouraged

- personal, interpersonal and intrapersonal intelligences are used in interacting with others, and in understanding and exploring the self.

5.5.3.4 Best Practice

The project can be considered as a model of good practice because it promotes participation through active, experience-based engagement in the Arts.

The activities are personal and recognise the value of participants past experience as a resource for making and appreciating art and for future learning. Older people can be empowered through the development of relationships of equity, trust, ease, friendship and sharing between participants, as well as between facilitators/other staff and participants. The importance of the principle of reciprocity in the relationship and learning between participants and artists involved in the projects contributes to a sense of self among older people. The projects utilise partnerships with other agencies including the SHB, Age and Opportunity, and ARAs to maximum effect and mutual benefit.

5.5.3.5 Lessons from the Project

Leadership and the backing of Government, policy-makers and management in healthcare organisations are required, as well as the support of arts development organisations such as The Arts Council and the Department of Arts, Sports and Tourism. The programme hopes to continue to develop partnerships, advocating for Arts programmes to be placed at the core of healthcare systems and community-based programmes. The challenge is to try to move away from pilot projects into long-term programmes which require serious and long-term commitment of resources.

5.6.1 FORUM Social Care Project

5.6.1.1 Description of the Project

FORUM is a community/rural development project which is operating in the North West Connemara area since 1989. The aim of the project is to tackle problems of disadvantage and isolation experienced by the following target groups: older people; people with disability; young people; women and families; community groups; and unemployed people.

The current social care programme emerged from FORUM's work setting up resource groups, delivering a primary healthcare project, setting up carers' support groups and coordinating a rural transport project for older people. The programme is operated through two FÁS CE Schemes and a team of workers who provide services including meals on wheels, laundry, home visiting, information, essential housing repairs and driver/attendants for Clifden Day Hospital. It also involves work with carers, a disability support project, an intergenerational project, social outings and respite breaks, a community transport project and security for older people. The project is coordinated by two full-time CE supervisors and a social care project worker, and provides a service to the entire North West Connemara area, delivered by a team of thirty-four social care workers. The project serves 374 clients delivering nearly 300 meals on wheels each week and providing over 100 home visits.

The project aims to ease isolation and loneliness experienced by some older people and to support older people to continue to live independent lives in the community.

5.6.1.2 Values and Philosophy of the Project

The project addresses the gaps in conventional services to older and vulnerable people in North West Connemara and equity is, therefore an important element. The participation of older people is crucial to the success of the programme and the concept for the initial social care programme in the Ballinakill parish was put forward by the Ballinakill Active Age club. Empowerment, partnership and choice are essential aspects of the project. The project seeks to put the older person at the centre of the decision-making process with regard to local services and the local environment.

5.6.1.3 Outcomes of the Project

The project has had the following outcomes:

- the programme is successful in 'coordinating and integrating a wide range of services' (Canavan and McGrath, 2001)
- the programme has had a positive impact on the well-being of older people and on the social care workers who have been trained and developed in the area of social care (Canavan and McGrath, 2001)
- the programme complements the services provided by the statutory agencies in the area
- the social contact provided by the workers is a major benefit of the project in that this provides a link between the older people and other services, e.g. day care, thus increasing the uptake of these services. Visits to older people help ease isolation and loneliness and increase the sense of independence and quality of life experienced by older people
- the assistance provided through the project enables older people to remain at home thus avoiding the cost of full-time nursing care to the State.

5.6.1.4 Best Practice

The structure of FORUM, a locally based development project, includes all the relevant players acting in partnership to implement and develop the programme. These include the local community, the Western Health Board (WHB) and FÁS, which allows for cost-effective and coordinated delivery of a wide range of services in a dispersed rural area. Community consultation in assessing the needs of older people and ongoing consultation with community groups and health personnel to identify needs has been a core element of the project. The emphasis on information-sharing and evaluation has informed the development of the project.

5.6.1.5 Lessons from the Project

The delivery of a social care programme using the FÁS CE Scheme does give rise to problems in terms of planning and sustainability as the FÁS criteria lead to high staff turnover, which can have a destabilising effect. Ongoing cutbacks of CE participants contribute to a situation where there are fewer workers to deliver services while demand is increasing. Funding for community-based social care services is inadequate and this gives rise to difficulties in service delivery.

5.6.2 Midland Health Board Diabetes Shared Care Project in Primary Care

5.6.2.1 Description of the Project

In 1996, the Midland Health Board (MHB) set up a project to develop a model of care for people with diabetes in primary care. The first primary care project was piloted in 1997. A pilot system of shared care, prioritising Type 2 diabetes was then piloted by the Board in 1998, involving ten GPs providing services to 392 of their diabetic patients. The project involves the provision of evidence-based medical, nursing, dietetic and chiropody care to diabetic patients in primary care. The core aims of the project were to raise the overall standard of care for people with diabetes and document the barriers to implementation.

Clinical guidelines were drawn up for participating GPs and provision of services to the practices by community nutritionists and chiropodists were agreed. All ten practices were audited and feedback given to GPs on an individual basis. This project was implemented in a region with no consultant-led endocrinology service for people with diabetes and catered for people with both Type 1 and Type 2 diabetes, three-quarters of whom are 55 years and older.

Since August 2001, the Diabetes Shared Care Project has been linked to the Cardiovascular Health Strategy under the Department of Public Health and Planning. The project is currently implemented through the Multidisciplinary Primary Care Working Group of the Cardiovascular Health Strategy. It has been further developed by Cardiovascular Health Funding and will continue as part of the National Secondary Prevention of Cardiovascular Disease Programme in General Practice ('Heartwatch'). There are now twenty practices involved and 1,300 patients were recorded in the 2002 audit.

5.6.2.2 Values and Philosophy of the Project

The purpose of the MHB Diabetes Shared Care Project under the Cardiovascular Strategy is to offer high quality, equitable, effective and efficient services to the diabetic population of Laois, Offaly, Longford and Westmeath. Type 2 diabetes is often considered a disease of an ageing population, and one that is likely to increase with rising levels of obesity and physical inactivity in Ireland. This project also evaluated the effect of changed care processes on health outcomes for diabetics including consideration of the costs of implementing these changes. The project ultimately sought to maximise return per unit cost of resources consumed.

5.6.2.3 Outcomes of the Project

The project has had the following outcomes:

- people with diabetes can access almost all of their diabetes education and care, both general and specialised, in a local setting
- care is now delivered according to standardised guidelines throughout the practices within the Board's area
- protocols for referral between services are in place
- a Primary Care Diabetes Liaison Nurse has been appointed. The provision of clinical and educational support for the project staff as well as liaising with hospital staff on guideline development are central to her role. This provides patients with specialist nursing backup at practice level and should act as a motivating factor for both patients and practice staff
- an *Audit Report of the Midland Health Board Diabetes Shared Care Project 1998-1999* has been published and a repeat audit and evaluation is nearing completion.

5.6.2.4 Best Practice

The project is implemented in the patients' own community by professionals with specialised knowledge of social, economic and health issues relating to diabetes. It is based on best evidence of international practice, is protocol driven and is supported educationally. Research and audit continue to be an integral aspect of the project. This facilitates evidence-based prioritisation of development within the project on an ongoing basis. Process and outcome of care measures are used as indicators of quality of care received.

5.6.2.5 Lessons from the Project

Funding is a critical issue and should be ring-fenced from competing demands. An appropriate needs assessment of the resources, personnel, equipment, training required etc, is essential for good planning. The development and fostering of good communication links and interaction between primary and secondary sectors in relation to the project is also important. Good communication enhances protocol development and implementation across the care settings for this group of people. Consistency of information is also a reassuring factor for older people involved in the project.

5.6.3 Falls Prevention Programme

5.6.3.1 Description of the Project

The Falls Prevention Programme in Baltinglass District Hospital began as a research project. Its aim was to reduce the number of falls and resultant injuries experienced by patients. Intrinsic and extrinsic factors were considered. All grades of staff completed a questionnaire with the intention of identifying potential hazards. From the completed questionnaires a number of risks were identified and a programme was put in place to reduce these risks. Data on falls and resulting injuries for the year prior to the intervention were compared with equivalent data after Year One and Year Two of the intervention.

5.6.3.2 Values and Philosophy of the Project

The underlying philosophy of the project is that prevention is better than cure in relation to falls and the associated injuries among older people. The evidence suggests that prevention is possible and should be considered essential to reducing the physical and psychological effects of falls on older people. The project is also likely to be a cost-effective exercise for the health sector.

5.6.3.3 Outcomes of the Project

The project has had the following outcomes:

- 21 per cent fewer falls were recorded in Year One, and 49 per cent fewer falls were recorded in Year Two, than had been recorded in the pre-intervention year. The difference was statistically significant in Year 2
- in both intervention years there was a significant reduction in the incidence of fracture – from 21 per cent of falls (pre-intervention) to 3 per cent in Year One and no fractures in Year Two
- significant reductions in soft-tissue injuries occurred in Year Two but not in Year One, dropping from 39 per cent (pre-intervention) to 15 per cent in Year Two
- the percentage of patients uninjured after a fall increased from 41 per cent (pre-intervention) to 85 per cent in Year Two
- the intervention reduced falls and their adverse consequences for older people living in the long-stay unit. The positive effects of the intervention increase over time.

5.6.3.4 Best Practice

The project was based on needs assessment and environmental audit involving all staff, so the response fit the specifics of the unit. Information was gathered and shared amongst all staff members. The project evaluated meaningful outcomes and sought to preserve the autonomy of older people.

5.6.3.5 Lessons from the Project

Awareness of the potential risk factors for falls (intrinsic and extrinsic) is key. The identification of individual risk factors for falls in such units is important and lays the groundwork for action. The positive results of this intervention would suggest that these units should institute falls prevention programmes. In-service training programmes for all levels of staff should include consideration of falls prevention. Identification of older people at high risk is also recommended with a view to using hip protector pads. The programme could be extended to older persons attending the day care centre with the co-operation of community service employees.

5.7 Conclusions

The projects described in this chapter are representative of the types of project included in the Healthy Ageing Database. Each of the case studies contains important elements of best practice. They are all empowering in one way or another for older people. The importance of participation and of placing older people at the centre of the decision-making process shines through in all of them. All of the projects considered in this chapter had clear objectives and a strong set of values to underpin them. These two fundamentals provided the basis for sustained progress even where obstacles existed. Partnership was also central to the operation of most of the projects considered in this chapter. Information-sharing is an important aspect of best practice in healthy ageing and one can learn something from all projects, even those outside of one's particular area of interest. This is the value of the new Database. It provides baseline information and contact details for over 350 projects across the country, as well as facilitating learning and the exchange of ideas in this important field.

Chapter Six

Best Practice in Healthy Ageing

Chapter Six

Best Practice in Healthy Ageing

6.1 Introduction

This chapter is concerned with best practice in healthy ageing in Ireland. It builds on the seminar discussion on best practice in Chapter Three. While best practice means different things to different people, a number of common themes emerged from the seminars including empowerment, participation, consultation, partnership, continuity, sustainability, equity, information-sharing, monitoring and evaluation. These themes were raised again in the survey carried out for this Report, which provided respondents with an opportunity to outline their interpretation of best practice in the healthy ageing field.

The aim of this chapter is to demonstrate practical applications of best practice using two hypothetical case studies. We have chosen one hypothetical example from the community in order to emphasise choice, autonomy and empowerment for older people, and one hypothetical example from residential care to emphasise the importance of consultation, participation and empowerment in healthy ageing projects. Needs assessment is an essential part of both projects. We provide a checklist against which practitioners can plan and compare their own projects. The aim is to provide a practical, learning-based, discussion of best practice which acknowledges some of the theoretical issues in the field but provides essential, practical advice to practitioners on how to make progress within their own particular project.

The two hypothetical projects are 'gold standard' in the sense that they incorporate all elements of best practice. In reality, the absence of resources, time constraints and personnel shortages means that very few actual projects can hope to meet all the criteria set out below in relation to best practice. Nevertheless, the two hypothetical examples illustrate what might be achieved if more attention was given to best practice in the design and implementation of projects.

6.2 Elements of Best Practice

As noted previously, the seminars facilitated wide-ranging discussions on best practice in the field of healthy ageing, exposing a number of interrelated themes that subsequently informed the question on best practice included in the survey of healthy ageing projects. The survey asked project leaders to rank the most important elements of best practice in relation to the development and operation of healthy ageing projects and services for older people. Table 6.1 shows the response to this question. Many of the same issues raised in the seminars came up again, which is not surprising given that the prompts for this question were partly based on the seminar discussions. Consultation and needs assessment received the highest percentage of number one rankings from respondents.

Sustainability was also considered a very important aspect of best practice receiving 20 per cent of first preferences. Indeed when all rankings are aggregated for each item, sustainability at 22 per cent was considered the most important aspect of best practice. Evaluation performed poorly on first preferences but recovered when all rankings were aggregated receiving 14 per cent of the total preferences.

Equity was not considered an important aspect of best practice receiving only two per cent of all preferences expressed by respondents. Similarly, participation was hardly mentioned at all but in this case respondents may have felt that needs assessment and consultation incorporate participative elements and therefore there was no need to explicitly mention it in the rankings.

The criteria established in the survey are here applied to two fictional projects as a demonstration of the practical application of best practice in the development and operation of healthy ageing projects. The two hypothetical projects created are as follows:

- a choice model of community-based provision for dependent older people
- promoting independence and autonomy for older people in residential care.

Elements of these models may already be in place across the country, but it is unlikely that they directly match any existing healthy ageing projects nor are they intended to. Any likeness to existing projects is accidental and coincidental.

Table 6.1: Elements of best practice

Elements of best practice	A Rank 1 %	B Rank 2 %	C Rank 3 %	Total
Consultation	28	12	7	16
Needs assessment	27	12	5	15
Sustainability	20	21	28	22
Partnership	8	11	8	9
Empowerment	7	15	11	11
Evaluation	4	10	35	14
Information-sharing	4	17	11	10
Equity	1	1	4	2
Participation	1	2	0	1
Total (%)	100	100	100	100
N	138	113	97	358

6.3 A Choice Model of Community-Based Provision for Dependent Older People

6.3.1 Description of the Project

This healthy ageing demonstration project is set within the older person's own home. It is health board-run and its objective is to place older people at the centre of decision-making in their own homes in the community. Citizenship, empowerment and participation are the core values underpinning the new system. The current in-kind provision of community care (where resource allocation decisions are made by health professionals and administrators) is replaced by a cash allocation system with money paid directly to the older person and tied to community care usage. Older people are assigned to three categories of dependency (moderate, high and continuous), and are given an appropriate budget reflecting their dependency and need for community-based social care. They receive weekly cash payments which they can use to purchase various community care services. Alternatively, they can use the money to pay for family care. The maximum weekly cash payment is €250 per week. Older people can use the money as they see fit but they must provide

receipts to show that the money is used for social care services, including family care. It is only in exceptional circumstances, in the case of mental impairment, that decision-making with respect to care provision is taken away from the older person.

6.3.2 Examination of Elements of Best Practice

Now we examine how each of the elements of best practice listed in Table 6.1 might be implemented in such a hypothetical project.

6.3.2.1 Needs Assessment

Information was collected on the current and projected number of older people in the relevant catchment area, followed by an estimate of the number of dependent older people and the extent of dependency in that population. The level of dependency was assessed by means of a survey carried out by the Public Health Nurses (PHNs) using a standard activities of daily living (ADL) instrument and a mental status questionnaire (MSQ). Existing provision was documented, together with a detailed mapping of services to need in order to identify gaps in the system. Coordination problems and integration issues were also identified as part of the needs assessment process. Interviews with key providers were undertaken and focus groups of older people were used to elicit the views of recipients and potential recipients of existing services on how the new choice model might be implemented.

The needs assessment showed that statutory community care provision is currently limited to community nursing and home help services. Provision in other areas (whether statutory or voluntary or a mixture of both) is uneven, particularly with respect to day care, transport, home respite, night-sitting, home repair services and sheltered housing. Some of these services are not deemed core areas of provision by the health board while others pose problems of coordination particularly between the statutory and voluntary sectors. Older people wanted a more comprehensive range of services and more choice about the services they received from the public sector. They also wanted more consultation in respect of both the type and timing of services offered to them.

6.3.2.2 Consultation

Older people were consulted as part of the needs assessment about the nature and scope of existing services, as well as gaps in existing provision. Consultation was through the medium of two focus groups. One brought together recipients of existing community-based services and was based in the local day care centre.

The second focus group consisted of participants who had no contact with existing services and involved older people from various community-based organisations including the local ARA, St Vincent de Paul, the Irish Countrywomen's Association (ICA) and the local Bridge Club. The emphasis in both focus groups was on choice and the decision-making process in regard to community care provision. Older people were asked how they thought choices were currently made and how they thought choices should be made. Those currently receiving services were asked if these were the services they wanted and whether they would purchase any additional services if they were given the opportunity. Both groups were asked for their views on the practical application of a new cash-based system for community care provision.

6.3.2.3 Participation

A Steering Group was established by the health board to oversee the development of the project and four older people were invited to join it. Because of the absence of appropriate and representative advocacy group for older people in the region, the four older people (two male and two female) were selected from the focus groups set up to elicit the views of older people on existing provision in the region. Two of the older people were currently users of community care services and two had no contact with the existing provision.

General recipients of community care services also had an opportunity to participate in the project through their ongoing involvement in user panels for each of the four main sectors of community care provision: home care; transport; day care; and housing. These user panels meet monthly to discuss service provision and coordination issues, reporting back to the Steering Group on any problems being experienced by recipients of the services. There is also an annual health forum to which all older people served by the project are invited. They have an opportunity at that meeting to air their views on the nature of the care provided, including organisational and integration issues.

6.3.2.4 Empowerment

Older people are at the centre of the decision-making process, rather than passive recipients of care. They receive cash allocations and are free to spend that money on specific community care services they feel they need. If a person wants home-based physiotherapy instead of home help then this is how they allocate their budget. Similarly, if people want a night-sitting service they are free to search for private provision of this service if no public service is available. The cash allocations can be used to buy services from outside the health board sector. Older people determine

their own package of care, albeit in consultation with family members and designated care managers who can act as brokers in finding the appropriate services for the older person. The money can be used to support approved and certified own-family provision of care. What is important is that older people remain in control of their own lives, even if their dependency on others may have increased.

6.3.2.5 Partnership

Partnership is central to this project. The primary partnership is between the older person and the health board. The project has its origins in the health board and the project is run by the Director of Services for Older People. There are also representatives on the Steering Group from social and voluntary housing organisations, social economy providers, GPs, local community hospital and private nursing home providers, reflecting the integrated nature of the project. The inclusion of representatives from the residential care sector reflects the focus on the continuum of care for older people and the need to maintain a clear link between community and residential care for older people. Carer's groups are also represented on the Steering Committee. So too is a representative from the local Alzheimer's support group.

6.3.2.6 Sustainability

The project was funded as part of a new Government initiative of demonstration project awards based on a competitive tendering process. The grant is for three years and incorporates existing funding for older people in the region served by the project. The key change relates to decision-making with respect to resource allocation. The older person can now decide what services to purchase, when and where. A decision on renewal of the project will be based on the external evaluation that is being conducted as part of the project. Sustainability depends on the success of the project in meeting the needs of older people in a way that is better than the previous allocation system. Economic theory tells us that giving people money rather than in-kind provision of services enhances choice and improves the well-being of people. The evaluation will tell us if this is true or not. Sustainability cannot be taken for granted and will depend on the outcome of the evaluation. This is true of every project.

6.3.2.7 Evaluation

Internal evaluation has been built into the project from the beginning. Data is routinely collected on costs and resource allocation, based on the choices made by the older people involved with respect to care providers and service delivery.

Baseline dependency established at the start of the project is collected annually. Older people are assessed on health promotion outcomes, intermediate health outcomes and final health and social outcomes. Examples of health promotion outcomes include changes in behaviour, changes in health-related knowledge and empowerment issues. Intermediate health outcomes include access to and appropriateness of health and social care services, housing accommodation, family care availability and provision of preventive services. An audit of health and social outcomes will form part of an annual assessment during which morbidity, mortality and quality of life data will be collected on the population served by the project. An external evaluation funded by the health board will be carried out in the third year of the project and will help determine if the project should receive funding beyond the current three-year allocation.

6.3.2.8 Equity

All older people living within the area served by the project are, by definition, included in the project. The level of dependency determines the cash grant received. There is no discrimination by income, class or gender. Older people with literacy problems are given support by the care manager where problems arise with form-filling and other administrative issues. People with dementia and related cognitive impairments are also supported in the decision-making process by the care manager, based on a philosophy of person-centred care. Some older people decide not to participate in the project, which is their right. These people continue to receive community care services on the basis of need, as determined by statutory providers.

6.3.2.9 Information-sharing

There is a free quarterly newsletter for older people served by the project entitled *Choice*. It is produced by a team including users, a care manager and local transition year students, thereby providing an important intergenerational component to the project. The newsletter is funded by revenue from advertising. Information is provided on existing and potential services for older people, entitlements and health promotion. Family carers' groups and the ARA use the newsletter to communicate with members.

There is also a dedicated website for the project. Older people can communicate electronically on issues dealing with problems of choice, as well as the range and quality of services available in the region. People from outside the region can also see how the project is operating. There is annual report for the project which includes basic data on dependency, provision and need in the region. The final evaluation of the project will be published in hard-copy and electronically.

6.4 Promoting Independence and Autonomy for Older People in Residential Care

6.4.1 Description of the Project

This project involves promoting independence for older people in residential care, specifically in a private nursing home. For many older people, admission to both public and private long-stay care is associated with a loss of choice, independence and usefulness (Secker *et al.,* 2003). It may be necessary for people to be admitted to long-stay care but the loss of independence is an unwelcome by-product of the care provided. Therapeutic care is sometimes delivered in a way that undermines independence because it is delivered for the convenience of care staff rather than residents. Examples include unclear communications, 'talking over' residents, taking over activities from them and not taking residents' views seriously (Secker *et al.* 2003). According to Wright (1985) patients or residents cared for under this type of 'restrained' model are deprived of choice and participation and are essentially 'batch processed'.

The opposite approach is a 'supportive' model of service delivery which is characterised by consultation and involvement of the older person in the care regime (Wade *et al.,* 1983). The process of care under this approach is consumer oriented with much of the impetus for activities and service delivery originating with the older person. This hypothetical project develops the concept of a 'supportive' model of care within a private nursing home setting. The project seeks to create opportunities for residents and staff to cooperate in order to provide higher levels of well-being for both parties. New structures and processes are created to allow residents some input into care decision-making, including such areas as therapeutic contact, person-centred care, opportunities for work, entertainment, meal times, nutrition and opportunities for personal and social communication.

6.4.2 Examination of Elements of Best Practice

6.4.2.1 Needs Assessment

The aim of the needs assessment was to explore the range and diversity of views held by older people living in the residential care setting with regard to independence and participation in the running of the institution. The needs assessment was funded by the health board and carried out by an experienced researcher in qualitative methods who was not known to either staff or residents. Quota sampling was used

to ensure that sufficient men were surveyed and that an adequate number of older residents were included in the study. Care was also taken to ensure that quieter older people were included and that people with hearing impairments were interviewed. Older people were interviewed alone or, if they preferred, with one family member or friend. Initial contact was made on an informal basis and some effort was made to build up trust between the researcher and the older person. Staff were not present at the time of the interview. Staff were, however, interviewed separately on issues of independence and participation.

The results of the needs assessment suggested that older people wanted more involvement in the running of the nursing home. They wanted more say in the types of service available and the way that these services were delivered. They wanted a reduction in planned routines and more opportunities for personal, creative and social development. Some residents expressed a willingness to contribute to domestic duties. In addition, there was a desire for more choice about the food in the nursing home and more flexibility on the timing of meals. There was also concern about the absence of rehabilitation and diversionary therapies within the care setting. Residents also wanted more opportunities for redress should problems arise in any aspect of the care provided by staff. Staff expressed some of the same concerns about the difficulty of filling long days for residents, but were more circumspect in their attitude to any changes in models of participation in the nursing home.

As a result of the needs assessment the nursing home decided to introduce the new project in partnership with residents and the Health Board for a one-year period. Important lessons might be learned that could subsequently be applied to other nursing homes in the region and to the Board's own residential care units.

6.4.2.2 Consultation

Older people were consulted as part of the needs assessment about the nature and scope of existing participation in the nursing home. Qualitative interviews with residents were based on a core of seven open-ended questions adapted from work by Abbott *et al.* (2000) on social and democratic participation in residential care settings for older people. These questions were as follows:

- What part of the day do you enjoy the most?
- What part of the day do you enjoy the least?
- Compared to where you lived before, what is better about living here?

- Compared to where you lived before, what is worse about living here?
- What would make your life better?
- Some people say that independence is very important to older people. What do you think?
- Some people say that being involved is very important to older people. What do you think?

Consultation was ongoing and facilitated by the involvement of older people in a number of new structures within the nursing home through which the views of residents could be transmitted to management, families and the health board. These structures are outlined in the Section 6.4.2.3.

6.4.2.3 Participation

A House Committee was established within the nursing home to oversee the development of the participation project. The Committee consisted of two older people elected by the residents, the nurse manager, one member of the care staff, one representative drawn from the families of residents and a representative from the health board. The latter is included because of the large number of residents in the nursing home receiving public subventions and because of the desirability to strengthen the links between the community and the nursing home. The House Committee made decisions on process issues within the nursing home including access to care services, therapeutic services and diversionary services. Opportunities for personal, creative and social interaction were also considered by this Committee. Practical issues such as the timing of meals, nutrition, wake-up calls, décor and design were also discussed.

The views of residents are transmitted to their representative on the Committee through two residents' user panels. Residents were invited to sit on user panels and report back to their House Committee representative on practical problems arising from the operation of the project. The first user panel is dedicated to care services and considers issues such as levels and appropriateness of care, attitudes of care staff and access to rehabilitation and therapeutic services. The role and availability of statutory services in providing an input into the care process in the nursing home is one of the issues considered by this user group. The second user panel deals with personal, creative and social interaction. Issues considered by this user panel includes things such as opportunities for interaction and friendship

among residents within the nursing home, opportunities for artistic expression, social outings and access to computers and electronic communication.

6.4.2.4 Empowerment

Once again, older people are placed at the centre of the decision-making process, rather than being passive recipients of care. They have an input into what goes on in the nursing home where they now live. They do not have the same autonomy as when they lived at home but they have changed both the decision-making process within the nursing home and the services available to them. They are now consulted on all aspects of care, including staffing levels. They have succeeded in changing both meal-times and menus, having encouraged the proprietor to secure the advice of a nutritionist in deciding on menus. There is now more emphasis on rehabilitation in the nursing home with improved access to physiotherapy and occupational therapy. The introduction of new services in these areas was in response to demands by residents for better access. The range of possibilities for social interaction within the nursing homes has been extended, and there are now more quiet places where residents can meet and communicate. There is a weekly concert which includes contributions from residents, as well as a new book club. Five new computers have been purchased for the nursing home and an ongoing training programme on e-learning and communication technologies has been established.

Not all residents were interested in empowerment. The majority of residents had no obvious resentment to the care regime that existed prior to the introduction of the new project. This should not be surprising since it reflects the acceptance of an ageism culture generally in society. It would have been surprising if this nursing home contained a high proportion of older people seeking change. As part of the empowerment process, the project facilitated advocacy and training programmes desired to improve the self-confidence of residents and encourage their participation in the running of the home. Abbott *et al.* (2000) make clear that a necessary condition for more participation in long-stay care is to encourage and attend to dissenting as well as majority voices among residents. Improving self-confidence and awareness among older people is one of the ways to increase the number of critical voices within the resident population.

6.4.2.5 Partnership

The project has its origins in the nursing home but receives support and funding from the health board so there is public/private partnership with respect to funding. There are a number of key partnerships within the project. The critical one is the

involvement of older people in key decision-making within the nursing home. Care staff are also included as partners in the project. This is important because even though the project is designed to provide more opportunities for older people to participate in the running of the nursing home there are practical care issues to negotiate before full participation can be achieved. The health board are directly represented through their presence on the House Committee. Their participation is important because it copper-fastens the relationship between community care and nursing home care, which remains very under-developed generally in Ireland. Families are also represented on the House Committee, even if the form of that relationship is not very representative given the absence of family panels for nursing home care in this country.

6.4.2.6 Sustainability

The willingness of the nursing home to undertake organisational change to facilitate a new participative model of care for residents was the catalyst for this healthy ageing initiative and remains the most important factor in its future success. So far that willingness to change has been demonstrated on a number of fronts, as previously described. Whether the organisational changes that have taken place will lead to higher costs and ultimately higher charges for residents is not yet known, but the indications are that both costs and charges will increase. There are additional services now being provided in the nursing home, and residents also have more access to rehabilitation and diversionary therapies. On the other hand, it is possible that medication costs will decrease and healthcare costs decline if increased participation is associated with higher levels of well-being among residents. If costs and charges do increase the sustainability of the project beyond its current life-time will likely be called into question. A decision on renewal of the project will be based on the ongoing evaluation that is being conducted as part of the project. Sustainability depends on the success of the project in meeting the participative needs of older people in a way that is better than the previous system but within acceptable cost boundaries.

6.4.2.7 Evaluation

Internal evaluation has been built into the project from the beginning through the assignment of a part-time researcher to the project by the health board. An important element of the evaluation is an examination of the change process itself, given the requirement for a substantial shift in perspectives of both staff and residents in the nursing home. Data is also being collected on the various changes in resource allocation arising from the availability of new services for residents. Changes in costs are being monitored. Outcomes are being assessed in accordance

with the hierarchy of outcomes put forward by Nutbeam (1999): health promotion outcomes, intermediate health outcomes and health and social outcomes. Examples of health promotion outcomes in the project include improvements in the knowledge, participation and self-awareness of residents. Examples of intermediate health outcomes include improved access to rehabilitation facilities, better diet, and greater opportunities for personal and creative development. Health outcomes are also being monitored through the use of a Life Satisfaction Index (LSI) administered at the beginning of the project, at six months and at the end of the project.

6.4.2.8 Equity

All residents in the nursing home have the potential to benefit from the project, even if they have not expressed a desire for a change of regime. Information and training programmes are provided to allow all residents to explore and articulate their own needs within the context of existing models of care. Attention has been paid to the needs of certain categories of resident. Special provision has been made for people with hearing and eye-sight difficulties to participate in activities and in the consultation process. Residents who are confined to bed are provided with opportunities to consider optimal participation models from their perspective. People with dementia are also included through dialogue with family carers who are invited to contribute to the user panels set up as part of the project.

6.4.2.9 Information-sharing

Information on the project is available to all residents through a specially designed notice-board in the nursing home. Details of the members of the House Committee and the two user panels are available on this notice-board. A new website on the project is being set up as part of the development of e-learning and technology training opportunities for residents. The final evaluation of the project will be published in hard-copy and electronically.

6.5 Checklist for Best Practice

The two hypothetical case studies described above are demanding in terms of their adherence to best practice. It is unlikely that many existing healthy ageing projects will measure up when assessed against the criteria for best practice shown above. There are many reasons for this but funding, time and technical expertise are the

three most important factors. Funding is probably the most important issue, as projects rarely have the financial resources to allow them to undertake all aspects of best practice. For example, needs assessment is a critical aspect of best practice but it can also be expensive, particularly if surveys have to be undertaken. If you do not have the money it is difficult to undertake a comprehensive needs assessment. Time is also another crucial constraint for people engaged in healthy ageing projects. For example, people may simply be too busy running a project to think about the information-sharing dimension of the initiative. The third major constraint is technical expertise. This is particularly important in respect of evaluation since people may not have the skills to carry out a detailed analysis of their own project.

Despite these constraints, it is important to have the highest standards with respect to best practice, if only to identify where improvements can be made. Table 6.2 provides a checklist for best practice based on the information generated for this report from the seminars and the survey. The checklist is meant as a set of guidelines for people planning projects in the healthy ageing field. The aim is to encourage good projects and to facilitate critical self-examination by practitioners and funding agencies before committing resources to any project. The checklist is not meant to be demoralising in the sense of discouraging or disapproving of projects that fail to meet all criteria or address all questions. Rather, it is meant to be an important reference point for both practitioners and policy-makers to facilitate improvement and development in best practice in healthy ageing in Ireland.

Table 6.2: Checklist for best practice

Criteria	Questions
Needs assessment	☐ Has a needs assessment been carried out? ☐ What approach is used to collect and analyse the data? ☐ Have the needs of users and providers been considered? ☐ Can the needs assessment be done internally using the existing skills available to the organisation?
Consultation	☐ Have older people been consulted about the project at the planning stage? ☐ Is there ongoing consultation with older people during the project? ☐ Is the consultation at a level that can be understood by older people? ☐ Have any specific groups of older people been excluded from the consultation process?
Participation	☐ Is the philosophy of the project one of participation for older people? ☐ At what levels of the project is participation encouraged? ☐ How is participation encouraged? ☐ Are there any categories of older person excluded from participation?
Empowerment	☐ How is empowerment interpreted in the context of the project? ☐ How is empowerment measured in the project? ☐ What aspects of the project gives more voice, more choice, more autonomy and more power to older people?
Partnership	☐ What is the process of deciding on partnership in the project? ☐ Is the process democratic? ☐ Who are the partners in the project? ☐ What is the methodology of partnership and conflict resolution?

Criteria	Questions
Sustainability	☐ Is secure funding available for the duration of the project? ☐ What factors might undermine sustainability in the initial phase? ☐ What is the process of deciding on sustainability in the initial phase of the project is over? ☐ Is the evaluation important in determining sustainability? ☐ Are there explicit criteria for long-term sustainability of the project?
Evaluation	☐ Has evaluation been built into the project from the beginning? ☐ Who is carrying out the evaluation? ☐ Have they the skills necessary to complete the evaluation task? ☐ Have all of the steps necessary for a good evaluation been followed?
Equity	☐ Are all potential categories of older person included in the project? ☐ Have any groups been excluded on the basis of income, gender or disability? ☐ Is there a need for positive discrimination to ensure equity in respect of access and participation?
Information-sharing	☐ How is information on the project transmitted to participants involved in it? ☐ How is information on the project to be transmitted to people external to the project, both within the region and outside? ☐ In what form is the evaluation going to be published? ☐ Is there someone in the project whose task it is to share and disseminate information?

Chapter Seven

Evaluation of Healthy Ageing Projects

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Evaluation of Healthy Ageing Projects

7.1 Introduction

The analysis up to now has concentrated on the development of the Healthy Ageing Database and the identification of best practice in this field. There is clearly a lot of activity in the field of healthy ageing in Ireland with more resources likely to be allocated in the future. The relatively low life expectancy for older people in this country makes it imperative that additional funding is made available to reduce the life expectancy gap between Ireland and the rest of Europe. The problem, as always, is to decide where any additional funding should be spent. The key to improved resource allocation in this area is more and better evaluation of existing and potential healthy ageing projects. The purpose of this chapter is to provide a framework for the evaluation of healthy ageing projects for practitioners and policy-makers, thereby facilitating greater use of evaluation and more informed decision-making in the field.

Evaluation facilitates the measurement of efficiency and effectiveness throughout the life of the project and the sharing of that information with other people. Tight budget constraints and concern about value for money also mean that the benefits of all types of spending must be documented and compared. The gain to policy-makers from increased evaluation in the field of healthy ageing is the contribution that evaluation makes to a more rational allocation of scarce resources. If we know which projects are more efficient, or effective, or produce the largest health and social gain, then these projects can be allocated an increasing share of resources. Projects which give poor return for money can be discontinued. Evaluation is also important for practitioners anxious to demonstrate the benefits associated with their own work. In an increasingly competitive funding environment, practitioners are becoming aware that the likelihood of securing increased or prolonged funding depends on a favourable evaluation of their project. Moreover, evaluation can

provide evidence to both practitioners and funders that interventions have been, or are being, implemented as originally intended. This has led most practitioners in the field of healthy ageing to accept the need for evaluation, in theory if not in practice.

7.2 Methodological Issues

The evaluation of healthy ageing projects is complex, posing considerable methodological challenges, beginning with the definition of evaluation itself. Evaluation means different things to different people. The report of the WHO European Working Group on Evaluation in Health Promotion (Rootman *et al.,* 2001) provides a broad definition of evaluation capable of accommodating most of the available definitions. It defines evaluation as 'the systematic examination and assessment of a programme or other intervention in order to produce knowledge that different stakeholders can use for a variety of purposes'. This definition involves testing what works and what does not. Different healthy ageing projects require different approaches to evaluation. These approaches include a blend of quantitative and qualitative analysis of process, impact and outcome measures. Analysis of process measures involves investigating whether the project was delivered in the way it was intended to be delivered. Analysis of impact and outcome measures involves testing whether the project has succeeded in achieving its aims and objectives in the short- and long-term. It is clear, therefore, that evaluation involves critical exploration that goes beyond narrative and description. Evaluation involves the assessment of all costs and benefits associated with an intervention, analysed at the level of the individual and society.

Rootman *et al.* (2001) also identify four core elements of evaluation: participation; multi-disciplinarianism; capacity-enhancement; and appropriateness. This chapter builds on these core elements to provide a set of principles that might underlie the application of evaluation techniques in the field of healthy ageing. This initial formulation of principles is followed by a step-by-step guide to the evaluation of healthy ageing projects. The measurement of costs and benefits is given special attention. Evaluation in the Irish context is also discussed with reference to the principles outlined and the methodological guide provided for evaluation in this field. While this chapter is influenced by the recent deliberations of the Working Group, it does not confine itself to health promotion, drawing significantly on economic evaluation literature for guidance on measures of costs and effectiveness.

7.3 Principles for Evaluation

This section draws on economic evaluation and health promotion literature, as well as on the feedback from the seminars, to develop a set of principles upon which to base any evaluation of healthy ageing work. It is particularly important to integrate evaluation processes from the beginning of projects rather than as an after-thought, when it perhaps has become impossible to collect all the relevant data (Rootman *et al.,* 2001). Evaluation should be seen as an integral part of a project and funded accordingly.

Any set of principles for evaluation should also reflect concerns raised during the seminars about the importance of consultation with older people and empowerment of older people at all levels, including participation in the evaluation process. Moreover, healthy ageing is far from monolithic and one evaluation design will not fit all projects. The multi-disciplinary nature of healthy ageing projects and variations in scale mean that different types of evaluation may be required in different circumstances. Flexibility and appropriateness are, therefore, important in developing evaluation tools.

Given the increasing emphasis on value for money and rationality in resource allocation, an important principle for evaluation is efficiency in resource allocation. As Godfrey (2001) points out, the ranking of projects in terms of value for money may be very different if the analysis includes all resource use, including those provided free, and considers all benefits including those that are difficult to measure. The measurement of benefits is now a familiar theme in health promotion literature with many efforts having been made to provide a hierarchy of outcomes ranging from health promotion outcomes, through intermediate health outcomes to comprehensive health and social gain outcomes (Nutbeam, 1999). Outcome measurement is more difficult in the field of healthy ageing than in the general health field given the eclectic source and range of potential interventions, the community orientation of many of these interventions, and the time-lag sometimes involved between the intervention and potential outcome. Equity issues are also important, particularly the question of who gains most from healthy ageing initiatives. Interventions may appear cost-effective only because they are focused on healthy and wealthy individuals, thereby perpetuating existing and long-standing inequalities among individuals and social groups.

The following five principles for evaluation seem appropriate in the circumstances:

- integration
- participation
- flexibility
- efficiency
- equity.

7.3.1 Integration

Evaluation should be introduced early and integrated into all stages of the development of healthy ageing interventions. Integration from an early stage allows timely and relevant data to be collected using properly designed and tested instruments. Evaluations should draw on a variety of disciplines and consider a broad range of information-gathering procedures (WHO, 1998). Needs assessment is an important part of this process because it provides baseline information on needs and existing provision, against which the intervention can be measured. Without some indication of the nature and severity of the problem, it is difficult to make any judgement on the merits of the proposed solution. Integrated evaluation also ensures that the intervention has clearly defined objectives against which progress can be measured. This is also important because it provides a reference point for the measurement of progress. There should be short- and long-term targets and milestones against which ongoing progress can be measured.

Integration is also important for both process and outcome evaluation. Process evaluation analyses healthy ageing projects and activities as they are implemented. Outcome evaluation typically seeks to find out whether a project produces the changes intended. Integration is important for process evaluation because it facilitates the development of a comprehensive information system designed to monitor the relationship between budgets and resource allocation, as well as between inputs and outputs. Process evaluation involves the setting and monitoring of tasks so that information is available on who does what, when, to or for whom. This kind of detailed information on inputs is critical to building up a complete picture of the intervention and facilitates both internal and external audit of the resources used in the project.

An integrated evaluation approach also facilitates the measurement of health promotion outcomes, intermediate health outcomes and final health and social outcomes. Health promotion outcomes incorporate personal, social and structural determinants of health, each of which may, to greater or lesser extent, be susceptible to modification. For example, people can develop the personal and communication skills necessary to allow them to be more assertive in asking for their rights and entitlements, or to access information that enables healthier choices to be made. Intermediate health outcomes represent the determinants of final health and social outcomes. Changing these health determinants is very important in healthy ageing work. For example, changes in diet and changes in smoking behaviour can have important effects on final health and social outcomes. Both health promotion outcomes and intermediate health outcomes, must therefore, be measured from the beginning of the intervention because it is these effects that may act as the catalyst for later health and social gains. Intermediate and final health and social outcomes are longer-term, but protocols should be agreed early on to ensure that all of the relevant data is collected to reflect the multidimensional nature of outcomes.

7.3.2 Participation

Evaluation can be carried out by internal evaluators, external evaluators or by a combination of both. A participatory approach to evaluation attempts to involve all who have a stake in the outcome in order to take action and effect change (Springett, 2001), irrespective of who carries out the evaluation. Those with a legitimate interest in the evaluation process can include older people's representatives and advocates, community groups and organisations, health and other professionals, policy-makers, and local and national agencies (WHO, 1998). While external evaluators still have the highest credibility in terms of technical competence and objectivity, resources may not always permit their involvement in evaluation. In any case, there is an argument for the involvement of stakeholders in both internal and external evaluations, whether it is the design stage of the research, providing support with data collection or interpretation of the data. The involvement of practitioners in evaluating their own practice is both empowering and fosters sustainability. It is also important that members of the community whose health is being addressed, in this case older people, are part of the evaluation.

Generally, health promotion is increasingly defined in terms of values such as empowerment, autonomy and participation. Thus, it is logical that the process of evaluation of healthy ageing activities should be guided by similar values. A participatory evaluation environment is essential for the empowerment and

social inclusion of older people involved in healthy ageing activities. In practice, this means a role for older people in both the planning and implementation of any evaluation in the field of healthy ageing, including their involvement in steering groups or committees overseeing the work of researchers. The involvement of participants in evaluation will likely lead to more credible performance indicators given the local-specific knowledge that participants can bring to an evaluation, particularly in situations where generic measurement tools and techniques are either inappropriate or unavailable (Israel *et al.,* 1994). Fuerstein (1986, 1988) has outlined a model of participatory evaluation that includes agreement on the objectives of the approach, a common methodology, team-work and training in evaluation. The latter is very important if participants are to make an effective contribution to evaluation and their involvement accepted as credible by external evaluators, budget-holders and policy-makers.

Participatory evaluation also makes it more likely that the findings of the evaluation will be conveyed to all participants and stakeholders in meaningful, timely and appropriate ways. Having provided baseline information and helped to collect, order and analyse the data, the participants will likely be more amenable to modify their own behaviour or provision structures in order to improve the efficiency and effectiveness of the project, should the need arise. This makes it more likely that the project will effect change in the manner intended. Timely information also allows for ongoing modification of projects without having to wait until full evaluations have been completed and signed off by the appropriate regulatory or funding agency. Sometimes evaluations are not completed until after a project has finished, arriving too late to have any impact on the operation of the project and often generating considerable hostility. Participatory evaluation facilitates learning by doing, thereby allowing for modification of practice during the course of a project. The presentation of any evaluation will also be improved by the involvement of participants, making it more likely that both analysis and recommendations can be understood and implemented by participants.

7.3.3 Flexibility

The most rigorous and complete design for healthy ageing interventions would involve the random allocation of individuals to alternative interventions, through the application of a randomised controlled trial (RCT). The RCT generally requires careful selection and monitoring of patients under a strict research protocol that seeks cause-effect inferences with a high degree of confidence (Drummond *et al.,* 1997). This requirement is very difficult to deliver in the multi-dimensional, multi-factorial world of community-based healthy ageing interventions. Most social phenomena are more complex and relationships between variables are rarely

simple or direct. There is, therefore, a gap between the mainly clinical conditions for which experimental and quasi-experimental methods were developed and those in which the vast majority of healthy ageing interventions operate (Potvin and Richard, 2001). Even where the conditions for a randomised approach exist, the cost of implementing an optimal design may be prohibitive. Funding for evaluation is usually scarce and it is rare that budgets are so large that they can support an RCT with a longitudinal element. It is important, therefore, that evaluations incorporate innovative methodologies and approaches in respect of data collection and analysis, involving both quantitative and qualitative models. Sometimes the emphasis will be on quantitative data analysis, particularly where such data is easily generated. Other times, the use of phenomenological and ethnographic methods may be more appropriate depending on the circumstances and nature of the study.

The choice of evaluation methodology and the techniques of evaluation will be determined by the type of intervention to be evaluated and the research budget for the evaluation. There may be a need for flexibility in respect of variables to be analysed, data to be collected and hypotheses to be tested. It will not, for example, always be possible to measure outcomes fully or to prove causal relationships. This should not undermine the evaluation process, once the limitations of the evaluation are carefully documented and an acceptable and transparent methodology has been followed. It is important to state clearly the objectives of the evaluation, the approach to be used in the collection of data and the analysis. For example, if an evaluation claims to be a cost effectiveness analysis then it should be assessed according to those rules. It should not be judged using criteria associated with cost-benefit analysis or cost utility analysis (e.g. Quality Adjusted Life Years), both of which seek to measure outcomes. Similarly, a study designed to examine process and procedures should be judged on different criteria. The sophistication of the evaluation design should reflect the complexity of the questions to be addressed. The principle of subsidiarity should apply in that higher order evaluation techniques should never be used to examine relatively simple associational or process relationships.

7.3.4 Efficiency

In general terms, efficiency means that the costs of producing any given output are minimised and the gains or benefits to individuals and society are maximised. There are two types of efficiency, technical and allocative, each representing more a standard to be achieved rather than a representation of current realities. Technical efficiency is the narrower concept in that it accepts a particular objective as given,

for example a ten per cent reduction in smoking among a target population, or a five per cent reduction in falls among a particular older population group, and is concerned with how to meet this objective at least cost. Costs are linked to effectiveness, with the latter accepted as given and not subject to comparative scrutiny. Technical efficiency may also be understood in terms of generating the maximum possible sustained output for a given set of inputs, for example maximising quality of life among residential care older populations, for a given budget.

Allocative efficiency is the maximisation of benefits from all available resources in society or within particular budgetary allocations. Whereas technical efficiency asks the question 'given that some activity is worth doing, what is the best way of doing it?', allocative efficiency asks 'whether an activity is worth doing at all'. Should we, for example, have breast cancer screening programmes for particular categories of older women? Should we screen for prostate cancer among older men? Allocative efficiency considers both the costs and benefits associated with a particular project or intervention, no matter where they occur or on whom they fall, and in comparative terms. The viewpoint is a societal one and the aim is to maximise the total value of outputs produced within a particular resource allocation framework, so that no further gains in output or welfare are possible for society. In the context of the current Healthy Ageing Programme, the allocative efficiency question is whether we have got value for money from spending up to now. This is the most interesting question given scarcity of resources and the reality that choices regarding the allocation of those resources. Unfortunately, we do not know the answer to this question because of the absence of a culture of evaluation in the Irish public sector.

Resources for healthy ageing projects and programmes are limited. If we decide to use resources in one particular way, there is an opportunity foregone to obtain the benefits of using these resources in some other way. Economic evaluation involves identifying, measuring and valuing the inputs and outcomes of interventions to allow greater clarity in respect of the sacrifices made as a result of supporting one project over another and the subsequent implications for social efficiency. The emphasis is on providing guidance to policy-makers charged with allocating scarce resources amongst competing projects and programmes. At the moment in healthy ageing, choices are made on many different criteria, sometimes explicit but mostly implicit. It is often impossible to tell why some projects receive funding and others do not, and both local and national politics can influence current allocations. Economic analysis attempts to identify and make explicit criteria which may be useful in deciding among different uses for scarce resources on the basis of both technical and allocative efficiency.

It is impossible to set priorities unless there is appropriate information on the merits of various projects competing for public funding. Economic evaluation, by virtue of its concern with costs and benefits, is an appropriate methodology for generating important information on the merits of various interventions, but it has largely been absent from health promotion thinking on effectiveness. Funding agencies are interested in finding out which interventions provide the best return per unit of funding. Economic evaluation is, of course, only one such methodology and cannot be used on its own to make final judgements on resource allocation. It is particularly important in healthy ageing to integrate economic evaluation with other methodologies given the range of potential outcomes available and the complex nature of some of these outcomes.

7.3.5 Equity

Measures of outcome do not normally take distribution and equity explicitly into account. Equity involves some concept of fairness or justice in the distribution of a good or service. Resources may be allocated efficiently but inequitably, with inequalities persisting in relation to socio-economic group, location/region or disability. ARAs may, for example, sometimes only include people from similar socio-economic backgrounds. Some older people may not be able to participate in healthy ageing activities due to hearing or reading difficulties. Some people may live too far away from centres of population and not have access to the public transport that would allow them to participate in various healthy ageing activities. Each of these examples may require a public policy of positive discrimination to offset actual and perceived disadvantage. In general, more women than men participate in healthy ageing projects, pointing to the need to think about gender differences in respect of participation. The people most in need of healthy ageing interventions may, therefore, not always be the people who receive those interventions leading to the paradox of health promotion for healthy people. It matters, therefore, who participates in healthy ageing projects, particularly given existing concerns about health inequalities generally in Ireland.

When we think of equity in respect of healthy ageing programmes, is it in relation to resources or health outcomes or both? Given the many influences on health, equity in resource allocation is a more achievable goal than equalising health, given our current knowledge regarding how this might happen. For that reason, the main equity goal in the field of healthy ageing should be that of equalising access for equal need, assuming it is possible to get some agreement on the latter. We need to have both rich and poor people involved in healthy ageing projects, we need to ensure that projects are established in deprived areas, we need to increase the participation rate

of men in healthy ageing projects, and we need to ensure that older people living in rural areas have an opportunity to become involved in healthy ageing activities. Therefore, evaluations should clearly set out barriers to participation in the project. For example, older people may be prevented from accessing services or activities that are health promoting because of lack of public transport or through literacy problems which present a particular barrier in relation to form-filling. Stigma can also be a significant barrier to older people accessing the services that are available to them, indicating the need to reorient services to suit the true preferences of older people themselves (Garavan *et al.,* 2000). The evaluation should provide information that allows questions of participation and equity to be formally addressed.

Equalising access by class or geographical area may, however, lead to efficiency-equity trade-offs, which may prove difficult for policy-makers to accept. For example, delivering healthy ageing interventions to people living in remote areas may be desirable from an equity perspective, but the cost of achieving this equity goal may be so high as to make it impossible for any government to consider funding spatially equalising healthy ageing programmes. Efficiency-based, economies of scale arguments are likely to supersede equity objectives whenever there is a clash between the two, as witnessed by the paucity of transport initiatives for older people in rural areas. This, in turn, raises important questions regarding the participation by individuals and groups in public decision-making. People may actually rank equity higher than efficiency, it is just that they rarely get the opportunity to make their preferences known in this regard.

The following factors which represent barriers to accessing and benefiting from healthy ageing projects should be considered under the principle of equity:

- functional factors
  - visual impairment
  - hearing impairment
  - cognitive impairment
  - physical disability
- educational factors
  - literacy (form-filling/IT literacy)
  - language (ethnic minority groups/use of jargon etc.)
- socio-economic factors
  - cost
  - time availability

- environmental factors
  - transport (access)
  - regional differences in access
  - caring role preventing time being available

- attitudinal factors
  - ageist attitudes
  - gender appropriateness
  - cultural appropriateness (religion/Travellers etc.).

7.4 Steps in Undertaking an Evaluation

Having established principles for evaluation, we now examine to the practical steps involved in undertaking an evaluation. The aim is to provide a checklist for people engaged in healthy ageing projects which they should consider when planning or commissioning an evaluation. Sometimes the evaluation will be conducted internally by the participants themselves, on other occasions external evaluators may be asked to complete the evaluation. Whether internal or external evaluators, the methodology of evaluation is equally relevant and in keeping with the principles set out above, all relevant stakeholders should be involved from the very beginning of the evaluation process.

Based on the evaluation principles, and following Rootman *et al.* (2001) evaluations in healthy ageing should consist of seven steps. These steps are as follows:

- description of the project
- choosing a perspective for evaluation
- database search and literature review
- methodology and design
- measurement of costs
- measurement of outcomes
- analysis and dissemination of findings.

What follows is a more detailed discussion of each of these elements with a view to providing a practical guide to people interested in initiating evaluation work on their own particular project or service.

7.4.1 Description of the Project

Before there can be evaluation, there must be knowledge and information about the project itself. The initial description of the project should provide information on its philosophy, followed by a clear statement of its objectives. It would be useful to document the extent to which the project conforms to the guiding principles for health promotion initiatives outlined by the WHO European Working Group on Evaluation in Health Promotion (Rootman *et al.,* 2001) as previously outlined. If empowerment and participation are important elements, then this must be communicated in the initial discussion. For example, to what extent is empowerment an explicit goal of the initiative and to what extent is participation. Holism refers to the need for a broad and integrated model of health production, incorporating physical, mental, social and spiritual health. A good description would provide information on the model for health production used in the project and an assessment of whether it is genuinely holistic. Similarly, information should be provided on whether the initiative involves the collaboration of different agencies from different sectors. There is also a need for some discussion of the main strategies employed to effect change such as policy development, organisational change, community development, advocacy etc. Information on whether the initiative is concerned with equity and social justice, and the nature of that concern if it exists would also be useful. Sustainability is the final element that should be considered in the initial description.

An important element in the initial phase of information-gathering is establishing contact with all major stakeholders. This is important for a number of reasons. Firstly, it facilitates the generation of information on activities, inputs, processes and outcomes thereby providing important context for the subsequent evaluation. Secondly, it facilitates a participatory model of evaluation in which staff and participants may be encouraged to provide support and help with the collection and interpretation of data (Springett *et al.,* 1995). Thirdly, it encourages a partnership model between the evaluator and the various interest groups associated with the initiative, thereby increasing the likelihood of acceptance of the evaluation process and its subsequent findings. This can be very important if the results of the evaluation suggest changes in work practices or organisational behaviour. Patton (1982) suggests setting up an evaluation task or consultative group as a means of facilitating the research process and increasing commitment to the results, but this may not always be necessary if the healthy ageing initiative is relatively simple and

small in scale. A consultative research committee can be important, however, in establishing and maintaining the credibility of the evaluation process where there is a large amount of data to be collected and where there are likely to be sensitivities regarding how information is collected and used.

7.4.2 Choosing a Perspective for Evaluation

The perspective for the evaluation of a healthy ageing project should include both health promotion and health economics components. Given the importance of participation in health promotion it is imperative that the evaluation process involves all the relevant stakeholders. This approach is not without its dangers, however, not least because it raises the possibility of bias and self-interest in the research process. Having a research protocol and a set methodology reduces the possibility of bias, particularly if supplemented by a code of ethics on the part of the researchers and the use of peer review at some stage of the evaluation. Interaction and dialogue are an important part of choosing meaningful outcomes and in the setting of appropriate objectives in the evaluation of interventions aimed at promoting healthy ageing, a view supported by hermeneutic theory.

Diversity is a central element in the evaluation of healthy ageing projects. This means the use of both quantitative and qualitative research tools to investigate costs, process and outcomes. While the RCT remains the 'gold standard' for evaluation research, the conditions for the application of randomised trials are nearly always absent. Therefore, multiple methods may be required to evaluate healthy ageing initiatives particularly when it comes to assessing effectiveness. McQueen and Anderson (2001) believe that an emerging theoretical perspective on health promotion, embracing participation, context and dynamism is now beginning to affect thinking on evaluation design. The implication of this new approach is a greater emphasis on multidisciplinary models of evaluation which take into account local factors and contexts. In practical terms, this means that evaluation teams should be multidisciplinary and that they should be capable of applying a range of different approaches to the measurement of costs and outcomes. What is very important is that the aims and objectives of the evaluation are clearly set out and are capable of being met using the appropriate methodology and the data set available for the analysis.

Economists believe that the appropriate perspective for evaluation is societal. That means that all costs and benefits should be measured and appropriately valued, regardless of their origins. For example, in a healthy ageing project run by volunteers, the opportunity cost of the volunteers should be taken into account. If the volunteers

were not working on the project, they would be doing something else. In other words, valuation become more difficult when the sacrifice includes non-paid work time or leisure time foregone, but techniques are available to deal with these issues. An evaluation that includes all costs and benefits ensures that healthy ageing projects that shift resource use to other health and social care budgets or to families, volunteers or older people would be subject to the same scrutiny as projects who bear the full cost of the initiative from within their own budget.

7.4.3 Database Search and Literature Review

An important element of the evaluation process should be to examine the nature and operation of similar projects elsewhere in the country. The Healthy Ageing Database (www.ncaop.ie) developed in conjunction with this Report will be an important source of information and reference for any new evaluation, it shows whether similar healthy ageing projects exist elsewhere and if evaluations have been carried out on such projects. It is possible to search the Database by location, by project setting, by project type and by category. If you are involved in a falls prevention project, for example, you can check if similar projects exist elsewhere and the current stage of development of such projects. The Database also contains information on the current status of the evaluation process, as well as the source and location of any completed evaluations.

If an evaluation already exists for a similar project elsewhere, then a judgement can be made on whether another evaluation is necessary. It should be possible to make such a judgement by subjecting the published evaluation to the criteria outlined in this chapter. Given the weakness of existing evaluations in this country, the likelihood is that new evaluations will be necessary for some time until a body of work has been developed.

All evaluations should have a literature review component. Internet search engines allow you to search for information using words or phrases such as 'health promotion', 'evaluation', 'healthy ageing' and 'ageing and economic evaluation'. Journals likely to contain peer-reviewed evaluations can be accessed by typing the name of the journal directly into the appropriate search engine, with many journals allowing public access and free downloading of articles. General search engines such as Google (www.google.com) or AltaVista (www.altavista.com) can also be used to locate both specific and general databases relevant to the evaluation of healthy ageing projects. Many of the general databases used in literature reviews, such as MEDLINE, are now available free over the Internet. An excellent example of a comprehensive literature review can be found in the evaluation on *Accidents in the Home: A Prevention Programme for Older People* (Scallan *et al.,* 1998).

International health agencies are also a useful source of data and literature. The following are particularly useful sources of information:

- WHO
- OECD
- Combined Health Information Database (CHID)
- HealthPromis.

The WHO provides a guide to health and health-related statistical information, as well as various online reports on evaluation in health promotion. The OECD provides a CD-ROM-based database of comparative data for thirty countries including information on health status, healthcare expenditure, ageing and demography. There are also two specific databases for health promotion which this author found useful in accessing literature on evaluation and health promotion. CHID is a bibliographic database produced by health-related agencies of the US Government. It provides titles and abstracts, as well as promotional and educational materials and programme descriptions not indexed elsewhere. HealthPromis is the national health promotion database for England. It contains references and links to a range of sources including official publications, surveys, reports, books, journal articles, websites and health promotion resources.

7.4.4 Methodology and Design

7.4.4.1 Setting Objectives

Rootman *et al.* (2001) have identified important design issues for the evaluation of health promotion projects. Not surprisingly, the first of these issues is the availability of clear and unambiguous statements on the goals and objectives of the evaluation. These must be explicit before any evaluation can take place. If they are not explicit *a priori,* then it becomes very difficult to establish the criteria for any examination of whether goals were achieved. The first task of planning is, therefore, to lay down the evaluation's objectives precisely. Any failure to think out the objectives of an evaluation fully and precisely will inevitably undermine its ultimate value as no amount of manipulation of the final data can overcome the resultant defects (Moser and Kalton, 1971).

7.4.4.2 Choosing Indicators

Once the evaluation's objectives are clearly set out, the next step is to agree the indicators to be used in the evaluation. Mostly the evaluation will be concerned with measuring performance against stated aims and objectives, so the emphasis will be on developing indicators to achieve this goal. There are two types of information, which you may want to collect: quantitative and qualitative. Quantitative information involves gathering information which can be counted, for example number of falls, numbers smoking, number of visits/services, drugs consumed, units of alcohol, before and after an intervention. Sometimes the indicators will be concerned with qualitative issues such as participation, integration, empowerment and citizenship. Qualitative approaches makes use of information which is not easy to count, or which might become meaningless if turned into figures, for example attitudes and values among the general public to ageing and ageism (Health Education Authority, 1999). An intervention might, for example, be concerned with the reason people hold the views that they do and how these views might be changed through judicious use of public policy instruments. The choice of indicators will ultimately depend on the perspectives and needs of different stakeholders, as well as the level at which the information is required.

7.4.4.3 Choosing Methods of Data Collection

In the majority of cases, the information-gathering process will be eclectic, representing the heterogeneity and multi-dimensional nature of many healthy ageing projects. Data collection procedures must remain rigorous and comprehensive irrespective of the methodology selected. If a survey is required, decisions must be made regarding the type of survey to be undertaken, whether the sample will be random, and on the type of random sample to be used. If formal questionnaires are to be used in the generation of data, decisions must be made on the scope of the questionnaire, the layout of the questions and the administration of the questionnaire. The latter is concerned with whether face-to-face interviews are necessary or whether, for example, questionnaires can be administered by mail, by telephone or via the Internet. Some of these decisions will simply require the application of commonsense but others will require careful consideration by/with experts in the field of social surveys and questionnaire design. The application of commonsense would mean that postal or telephone questionnaires should not be used if the population group suffers from poor hearing, poor eyesight or low levels of literacy. On the other hand, technical advice from experts will be required on the size of sample and on statistical testing if the survey is going to be used to make generalised statements about older people throughout the country.

The collection of information will likely be more successful if the principles of participation, integration and flexibility have been adhered to in the design of the evaluation. It is easier to collect data if all stakeholders understand the need for such information and the purpose of the evaluation. This is especially true where individuals are asked to provide a substantial amount of information to the evaluation team or to participate in face-to-face qualitative interviews or focus groups. Confidentiality may also be a key aspect of the data generation process and respondents will often need reassurance that the information they supply will be handled sensitively and with discretion. The training of interviewers is a fundamental part of the evaluation process, particularly if the evaluation is internally-based and requires sensitivity in the generation of data. There is potential for error at every stage of the data collection process but having well-trained interviewers reduces the likelihood of any controversy with respect to the handling of the data.

7.4.4.4 Undertaking a Pilot/Feasibility Study

It is very important to complete a pilot survey before going into the field with the final questionnaire. The pilot can be used to test the design and order of questions in a questionnaire, as well as its length, in the light of budget and time constraints. The size and scale of the pilot can be small and will depend on available resources but care should be taken to cover all possible response scenarios in terms of the variety of subjects chosen. It is impossible in such a brief overview to cover all aspects of the pilot stage of the evaluation process but considerable resources should be invested in absorbing the lessons of the pilot, whatever form it takes. If the responses to the pilot do not make sense in the context of all existing knowledge of the project, then something is wrong with the information collection process and procedures. Similarly, if people are giving stereotypical answers or too many incomplete or 'don't know' answers then remedial action is required before the process goes any further. The pilot survey, whatever its form, nearly always results in important improvements to the evaluation and a general increase in the efficiency of the enquiry.

7.4.5 Measuring Costs

Direct and indirect costs should ideally be measured in the evaluation. Direct costs refer to the measurement of health and social care services provided to participants in healthy ageing projects and are usually directly associated with the salary costs of paid staff involved in the provision of the intervention. Direct costs can sometimes be obtained from agency accounts but it may also be necessary to gather data on service use patterns and then to attach estimated unit cost measures. Indirect costs

include expenditures by families and other non-paid caregivers, volunteers working in health and social care agencies, together with any broader social impacts. The emphasis is on opportunity cost or the sacrifices involved in participating in a project whether payment is received or not. These lost opportunities must be valued and there are methodologies available for doing this. The interested reader is referred to Netten (1993) for a detailed discussion on various approaches. Sometimes, even where worthwhile methodologies exist, not all costs will be known precisely or there may be uncertainty with respect to valuing certain resources. In such cases it may be necessary to undertake sensitivity analysis in which a range of valuations are used to deal with this uncertainty and the reader can clearly see the assumptions underlying each valuation.

Knapp and Beecham (1990) have argued that costs should be comprehensively measured and should, where possible, be integrated with information on outcomes. In any comprehensive costing exercise it is important to note the distinction between average and marginal costs. The costs we are aiming to estimate will usually be associated with adding a new service or expanding an existing service. For a new service, average costs will reflect the relationship between total costs and some measure of unit activity or output. In the case of the expansion of a service, the focus should be on marginal or incremental costs. Marginal costs will be higher than average costs, for example, if an expansion of a service requires the replacement of volunteer workers by paid workers. Similarly, marginal costs will be higher if an expansion of a project requires the purchase of a new building or new equipment. In such circumstances, the correct comparison should be between the change in costs and the change in benefits arising from the marginal increase in resource use, both current and capital.

Capital costs are incurred by purchasing the major capital assets required by the project, generally equipment, buildings and land. Capital usually represents a big investment at a single point in time which may explain why it is sometimes ignored. Frequently, capital costs are not listed in the accounts or budgets because they have been funded in advance by a one-off grant or have been given as a gift by some sponsoring agency. The opportunity cost of capital relates to the funds tied up in the asset and the depreciation over time of the asset itself. Many approaches have been used to measure and value capital. The most popular approach is to annuitise the initial capital outlay over the useful life of the asset, thereby producing an annual equivalent cost for the capital outlay. This method automatically incorporates both the depreciation and opportunity cost aspects of the capital cost. Drummond *et al.* (1997) provides a useful tutorial on methods of measuring and valuing capital costs.

7.4.6 Measuring Outcomes

It is essential to assess the many and varied outcomes associated with healthy ageing interventions. Nutbeam (1999) provides a framework which helps to define the outcomes associated with health promotion activity. This framework can be used to examine potential outcomes from healthy ageing interventions. There are three levels of outcome in Nutbeam's model: health and social outcomes, intermediate health outcomes and health promotion outcomes. Health and social outcomes represent the end point of health and medical interventions. They are usually expressed as personal or social outcomes such as quality of life, functional independence, disability, dysfunction and ultimately morbidity and mortality.

In economic evaluation, outcomes are often expressed in terms of quality-adjusted life years (QALYs) whereby the changes in health state before and after intervention are measured by a combination of quality of life indices and life expectancy. QALYs measure health on a scale from zero (death) to one (perfect health) based on preferences generated either through asking participants involved in the project how they value changes in their health and social well-being, or, more likely, through the use of one of the pre-scored multi-attribute health status classification systems available (Drummond *et al.,* 1997). Currently, there are three main systems available – Quality of Well-Being (QWB), Health Utilities Index (HUI), and EuroQol (EQ-5D) – although the general application of these utility-based scales in health promotion has been called into question (Cribb and Haycox, 1989). This is because of the difficulty of incorporating important healthy ageing effects such as empowerment, self-worth, confidence and self-respect into existing measures.

Intermediate health outcomes are easier to measure than final health outcomes and represent the determinants of health and social outcomes. Changing these various determinants is a major objective of most healthy ageing interventions and therefore require close examination. Nutbeam (1999) outlines three potential health determinants: effective lifestyles, effective health services and healthy environments. Examples of lifestyles would include cigarette consumption, food choices, alcohol, illicit drug use and physical activity. Each of these is amenable to monitoring and measurement to ascertain the impact of the intervention on behaviour, and ultimately on health and social outcomes. Examples of effective health services include access to appropriate and timely health and social care services, such as ophthalmic and respite provision, and the provision of preventive services, such as cancer screening and counselling services. Examples of healthy environments include appropriate housing and transport conditions and services and supportive economic and social conditions. While easier to measure than final

outcomes, the measurement of intermediate health outcomes is also complex and multi-dimensional. Moreover, the precise relationship between these health determinants and final health outcomes is far from agreed and is the subject of ongoing discussion in the literature.

According to Nutbeam (1999) health promotion outcomes represent those personal, social and structural factors that can be modified in order to change the determinants of health. They are closely related to the principles outlined earlier in that they incorporate elements of participation, empowerment, information and knowledge for the participants of healthy ageing projects. Nutbeam identifies three dimensions of health promotion outcomes: health literacy; social action and influence; healthy public policy and organisational practice. Health literacy includes health-related knowledge, attitudes, motivation, self-esteem and personal skills. The prime outcome of some healthy ageing interventions may be to improve the knowledge of recipients, thereby allowing more informed choices to be made. In other cases the intervention may be directed at raising the self-esteem of participants, thereby enabling them to make better choices. Measurement is, of course, difficult but willingness to pay techniques may yield important information on how people value elements such as self-esteem, self-respect, empowerment and similar primary determinants of behaviour and response in healthy ageing (Rosen and Lindholm, 1992). Social action and influence incorporates elements of participation and empowerment and is concerned with the ability of individuals to gain access to, understand and use information to promote and maintain good health. Healthy public policy and organisational practice include aspects such as legislation, regulation, advocacy, resource use and organisational practice. Advocacy is a particularly important aspect of many healthy ageing activities and therefore it is important that some mechanism be available to monitor and measure its affects.

Equity should also be included in measures of outcome. It is important to know who is benefiting from various interventions. Does participation favour one social class or income group over another? Are the disadvantages of younger ages carried over into older ages? Are there gender differences within healthy ageing projects which need to be addressed? Do spatial issues matter for participation in healthy ageing projects? All of these questions can be addressed within a relatively straightforward analysis of participants on the basis of age, gender, education, current income, current sources of income, last occupation before retirement, lifetime occupation and current assets. While some people may view these type of questions as somewhat intrusive, and not all of them may be necessary all of the time, the reality is that many healthy ageing projects currently cater for certain categories of older person. Men are under-represented in existing healthy ageing

projects and so are disadvantaged older women and men. This is unfair and therefore projects should be judged on their inclusiveness as well as on the health and social outcomes of participants fortunate enough to be included.

7.4.7 Analysis and Dissemination of Findings

The analysis of the data must correspond to the stated objectives of the evaluation. For this to happen, the evaluator must understand the nature of the project being evaluated and have the confidence of all participants in the project. This will be more likely if all stakeholders have had a common understanding of the project from the beginning and participated in the data collection process. It is also very important that the evaluation contains a strong analytical component, otherwise it runs the risk of simply being descriptive, thereby adding nothing new to the understanding of good practice in healthy ageing.

If the evaluation seeks to address the effectiveness of a falls prevention project, the analysis must show clearly the impact of the project on the number of falls experienced by older people in the study group. If the focus of the project being analysed is, for example, on developing intergenerational contact within the primary education system, the analysis must document the quantity and quality of contacts between young and old in the primary education sector. If the project is about developing the creative and artistic abilities of older people the analysis must show if this occurred using both quantitative and qualitative data. The point of these examples is that the analysis must address the question posed by the evaluation directly. Evaluation should contain more than reportage and this is where good analysis is critical.

Following the analysis it should be possible to draw conclusions from the research and make recommendations for future action. Springett *et al.* (1995) point out that the involvement of stakeholders in the process means that they will likely already be committed to acting on the findings and be receptive to the results. Nevertheless, the conclusions should be clearly written and contain a statement on the merits or otherwise of the project. Recommendations should cover the immediate practical changes required, clarify what is useful and outline the resource requirements for any future development of the project. Reference should be made to the general lessons to be learned from the project, as well as the public policy implications of the project, if any. If the project has not met its aims and objectives, this should be clearly stated with reference to the problems associated with the project. If the view is that the project should be discontinued this should be stated explicitly in the recommendations.

Dissemination of the evaluation is an important part of the research process. Evaluations provide important information on what works and what doesn't, as well as on best practice, process and outcomes. Evaluation can provide the impetus for other communities and groups to replicate worthwhile projects. It can source problems and identify pitfalls for people involved in similar projects elsewhere. Information is also an important tool in empowering communities and individuals (Rootman *et al.,* 2001). It is essential, therefore, that where evaluations exist they are published and made available to policy-makers and the general public, particularly if the project is funded through the public purse. There is information in the Healthy Ageing Database on whether an evaluation has been carried out and where the completed evaluation can be sourced. This is a substantial improvement on the current situation where information on completed evaluations is piecemeal. There is, however, a need to go one step further and provide a clearing-house for evaluation reports with some interpretation by independent researchers on the merits or otherwise of completed evaluations. The NCAOP should consider setting up such a centre to which completed evaluations might be lodged and subject to critical assessment. The Council might also consider becoming involved in advising on the design and implementation of evaluations in the field of healthy ageing

7.5 Evaluations of Healthy Ageing Initiatives in Ireland

While there have been a relatively large number of healthy ageing initiatives in Ireland in recent years, the number of evaluations of such programmes and projects has been very limited. The projects that have conducted evaluations must be congratulated for doing so in the face of limited resources. The majority of the evaluations that have been carried out are, however, descriptive in nature, providing baseline information on projects rather than a systematic examination and assessment of their value to either recipients or society generally. Costs have been inadequately measured and benefits have been poorly conceptualised, with very little emphasis on measuring the outcomes associated with the various interventions.

The principal reason for this is the absence of any resources for evaluation in the Irish system resulting in organisations having to rely on poorly funded or own-time studies which can never be expected to deal adequately with the critical appraisal dimension of the evaluation process. Rootman *et al.* (2001) suggested that an allocation of ten per cent of total programme resources is a reasonable standard to ensure the development and implementation of appropriate evaluations of health

promotion. Very few Irish studies have managed to come near this guideline. To overcome the evaluation deficit, an evaluation fund should be established to support more rigorous assessment of healthy ageing projects. This fund could be administered by the NCAOP's Healthy Ageing Programme.

This section seeks to examine some of the evaluations of healthy ageing initiatives that have been conducted in this country in recent years in light of the five principles and seven steps previously outlined. Two important points must be made at the outset. Firstly, as the principles and steps are brought together for the first time in this Report, it would be unfair to judge existing Irish evaluations too rigorously, especially given the lack of resources in this area. Consequently, in the following review, a generous interpretation of whether the evaluation has met the principles and criteria outlined in this chapter is applied. So, for example, while the criteria suggest that the description of a project should include information on the philosophy of the project, the objectives of the project and on participants etc., the review is satisfied if the objectives of the project are clearly set out. Secondly, not all of the projects included in the review are actually evaluations, even within their own terms of reference. It may, therefore, be unfair to judge these reports as evaluations using the criteria developed earlier in the chapter.

Table 7.1 provides an overview of whether published Irish evaluations of healthy ageing initiatives incorporate the principles of integration, participation, flexibility, efficiency and equity. The evaluations perform well in relation to the first three principles. The majority of the evaluations generally adhere to the principle of integration. Similarly, the evaluations adhere to the principle of participation by including all relevant stakeholders in the evaluation process, although older people were not always consulted. The criterion used to assess flexibility was to determine if the methodology used by the evaluation team was suitable to address the question posed by the evaluation. It is difficult to judge some evaluations on this criterion because they fail to explicitly state the question(s) that the evaluation is attempting to address. Sometimes the methodology used is suitable to address some, but not all, of the questions posed by the evaluation. For example, the methodology may be able to determine if learning and self-awareness outcomes took place (an important health promotion outcome) but cannot shed any light on potential improvements in the health of participants.

Only one of the evaluations attempted to measure the efficiency of the project or programme in question. The evaluation of the Accidents in the Home programme (Scallan *et al.,* 1998) provides a good, if truncated, analysis of efficiency. Total expenditure on the programme, which attempted to improve safety at home among

persons 65 years of age and older, was estimated to be equivalent to the hospital costs of six hip fractures, but it was postulated that the programme had the potential to prevent a substantially greater number of serious injuries, thereby saving money in the future because of reduced hospital admissions. If the analysis is correct, the project would represent good value for money and those providing the service would have good grounds for looking for continued or increased funding.

There were missed opportunities in other evaluations with respect to the discussion of efficiency. In the evaluation of the Senior Help Line (Morgan, 1998), for example, a detailed analysis of the opportunity cost of volunteers, followed by an estimate of the alternative public expenditure approach to funding the service, would have shown more explicitly the cost advantages associated with the project. Similarly, in the Go for Life evaluation (Collier Broderick and Associates, 2002) some formal assessment of costs would have usefully demonstrated how much is being achieved in this programme at relatively low cost.

The final principle requiring consideration is that of equity. The absence of any consideration of equity is a serious shortcoming in many of the evaluations, as it is often people who are relatively healthy, wealthy and confident who participate in projects with the result that existing health inequalities are often exacerbated. Information on equity is important if the intervention is to be repeated or extended in an attempt to reach those who, for whatever reason, did not participate in the original project. The Go for Life programme evaluation is a good example in this regard. It attempted to determine who was participating in the exercise programme by gender, social group, educational level, house ownership etc. It was found that men and people from social classes four and five were under-represented and recommendations were then made about increasing their participation in the future.

Table 7. 2 outlines the steps that should be undertaken when conducting an evaluation and whether they were incorporated into the various evaluations. The shortcomings in the studies considered result in part from an absence of resources to carry out all of the steps. It is also worth noting the fact that not all of the studies were actual evaluations in the first place. One of the major shortcomings in the evaluations under review is the absence of meaningful outcome measures. Very few of the evaluations place sufficient emphasis on health promotion outcomes. Little information, for example, is provided on empowerment and participation of older people; two very important principles in health promotion that are regarded as legitimate outcomes in themselves. We cannot tell if this is because the people conducting the evaluations did not regard them as important or because they simply took them for granted. Some of the evaluations do include discussion on health

promotion outcomes. For example, the evaluation of the Ageing with Confidence programme (Clarkin, 2001) documents improved confidence levels and increased positive attitudes among some of the older people in that project.

A limited number of evaluations provide analysis of intermediate health outcomes. The evaluation of the Accidents in the Home programme (Scallan *et al.,* 1998) for example, used extrinsic and personal risk factors for falls and changes in safety awareness as legitimate outcomes, while the evaluation of the Influenza Vaccination Campaign (Kelly *et al.,* 1999) was concerned with vaccine uptake. Very few, if any, of the evaluations attempt to measure and value health and social outcomes. While health and social outcomes usually occur with a lag and often require extensive and expensive follow-up, it is rare for an evaluation even to make general reference to potential health and social outcomes. While acknowledging the difficulty of measurement, the importance of providing a clear and systematic account of the full range of benefits from the intervention, including health and social gain dimensions should not be underestimated. If people involved in healthy ageing projects want to be taken seriously by funders they must show the gains associated with their interventions and provide an argument as to why these projects deserve public funding.

As can be seen from the Tables, the evaluation of the Accidents in the Home programme performed well across all principles and steps. What then is it about this particular evaluation that differentiates it from the others? A number of points can be made in this regard. Firstly, the evaluation provides a detailed description of the programme outlining the rationale or the reasoning behind the introduction of the programme as well as its overall aims and objectives. These objectives, such as identifying environmental hazards in the home and where possible carrying out minor structural alterations to improve safety in the home, as well as setting out what the programme wants to achieve, provide outcomes by which we can measure the performance of the programme. Secondly, the evaluation chooses and describes a methodology suitable to determine if the objectives and aim of the programme have been achieved. Thirdly, statistical analysis is performed on the results, providing an independent and non-subjective assessment of whether the programme achieved its objectives. Finally the evaluation provides a discussion chapter, which interprets the results of the study, provides an assessment of cost-effectiveness and makes recommendations for the expansion or continuation of the project. While the Accidents in the Home programme evaluation (Scallan *et al.,* 1998) represents a good evaluation, this was probably helped by the nature of the study. For programmes that are more concerned with health promotion outcomes, some difficulty may be experienced in measuring and quantifying these particular outcomes. However this is not a legitimate argument not to evaluate.

Table 7.1: Principles for evaluation

	Go For Life[1]	The Senior Help Line[2]	Music in Healthcare[3]	Older Women's Health Initiative[4]	Bealtaine 2000[5]	Ageing with Confidence[6]	Tapping the Talents[7]	Accidents in the Home[8]	Influenza Vaccination Campaign[9]
Integration	✔	✔	✗	✔	✔	✔	✔	✔	✔
Participation	✔	✔	✔	✔	✔	✔	✔	✔	✔
Flexibility	✔	✗	✔	✗	✔	✔	✔	✔	✔
Efficiency	✗	✗	✗	✗	✗	✗	✗	✔	✗
Equity	✔	✔	✗	✗	✗	✗	✗	✔	✔

Not all of the studies looked at defined themselves as pure evaluations

1 Collier Broderick and Associates (2002)

2 Morgan (1998)

3 Wilkinson (2000)

4 Summerhill Active Retirement Group (2000)

5 Reid (2000)

6 Clarkin (2001)

7 Brophy (2001)

8 Scallan *et al.* (1998)

9 Kelly *et al.* (1999).

Table 7.2: Steps in undertaking an evaluation

	Go For Life[1]	The Senior Help Line[2]	Music in Healthcare[3]	Older Women's Health Initiative[4]	Bealtaine 2000[5]	Ageing with Confidence[6]	Tapping the Talents[7]	Accidents in the Home[8]	Influenza Vaccination Campaign[9]
Description	✔	✔	✔	✔	✔	✔	✔	✔	✔
Perspective	✔	✔	✔	✔	✔	✔	✔	✔	✔
Literature review	✔	✗	✗	✗	✗	✔	✗	✔	✔
Methodology	✔	✗	✔	✔	✔	✔	✔	✔	✔
Costs	✗	✗	✗	✔	✗	✗	✗	✔	✗
Outcomes	✔	✔	✗	✔	✗	✔	✔	✔	✔
Analysis/ dissemination	✔	✔	✔	✔	✔	✔	✔	✔	✔

1 Collier Broderick and Associates (2002)

2 Morgan (1998)

3 Wilkinson (2000)

4 Summerhill Active Retirement Group (2000)

5 Reid (2000)

6 Clarkin (2001)

7 Brophy (2001)

8 Scallan *et al.* (1998)

9 Kelly *et al.* (1999).

7.6 Conclusions

This chapter has been concerned with providing guidelines for the evaluation of healthy ageing projects in Ireland. The chapter set out five principles for evaluation followed by seven steps that should be undertaken in any evaluation. There are many different methodologies that can be used in the evaluation process so it is impossible to recommend one over the other without reference to the particular intervention being evaluated and related scale and funding issues. However, the chapter provides an important reference point for the evaluation of projects, irrespective of the methodological approach used.

The evaluation of existing healthy ageing projects in Ireland has not received adequate attention from either practitioners or policy-makers. There is a need to commit more funding to evaluations and build in an analytical process from the beginning of projects, in partnership with all stakeholders. Public funding for large healthy ageing projects should not be granted unless an evaluation process is intrinsic to the project. Good practice can only be replicated if it is known, and the only way it can be known is through good evaluation, comprehensively disseminated to all relevant stakeholders.

Chapter Eight

Summary and Conclusions

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8.1 Main Findings

8.1.1 General Findings

1. Ireland ranks lowest among European countries in terms of life expectancy at age 65, with a gap of 2.11 years between Ireland and the EU average. The gap appears to be increasing over time, having increased from 1.85 years in 1990. While the deterioration in the relative position of Ireland is apparent for both males and females, it seems to be driven by a deterioration in the relative position of females who are falling behind their EU counterparts faster than are Irish males.

2. In a ranking of healthy life expectancy for 23 developed countries by the WHO, Ireland ranked second last for males and last for females. Quality of life is measured by the time spent in poor health by people aged 60 in the countries covered by the survey. The gap between Ireland and the best performing country (Japan) for healthy life expectancy is 3.2 years for males and 4.6 years for females.

3. There are only four specific targets for healthy ageing in Ireland. These are in the areas of cardiovascular disease, cancer, accidents and smoking. The monitoring of progress in the implementation of *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998) is hindered by the absence of specific, measurable and time-scheduled targets for all the goals mentioned.

4. Although 24 goals are specified in *Adding Years to Life and Life to Years* (Brenner and Shelley, 1998), there is no ranking or priority setting, therefore we cannot tell which goal is the most important. Given limited resources, it is highly unlikely that all objectives can be achieved in a short period of time. The same point could be made about plans produced by various health boards for older people, which are generally weak on target setting, monitoring and priority setting.

5. Evaluation is largely absent from the healthy ageing field in Ireland. There is a tendency to confuse evaluation with description in the studies that have been done.

6. There is no uniform approach to health promotion for older people across the country. Some health promotion departments have health promotion officers for older people but the majority do not. There is no requirement for public health/health promotion departments to report progress in relation to the Health Promotion Strategy for Older People to a central body. No specific agency has been charged with the task of monitoring the Strategy.

7. A recurring theme at the regional seminars was the acceptability of different options for social interaction offered by community groups and health boards. A strong preference was expressed for the development of more community-based social activities that are participative and led by older people themselves. Participants viewed that opportunities for social interaction based solely in health board-run facilities were not essentially health promoting, primarily because the emphasis in these settings was placed on older people in terms of their care needs. Participants expressed the opinion that the most positive images of older people in Ireland were provided within the community/voluntary sector, providing better opportunities for the true voices of older people to be heard.

8.1.2 Regional Seminars

8. Participants in the seminars perceived that current funding for healthy ageing interventions is mainly tied to projects dealing with specific diseases, particularly heart disease and cancer.

9. Active retirement associations (ARAs) are perceived as the most visible face of healthy ageing in local communities.

10. Participants in the regional seminars identified the need to change attitudes to ageing as the most important priority for the future in the field of healthy ageing in Ireland. The view from the seminars was that older people are being discriminated against, not always consciously, due to an ageist culture that undermines their continued contribution to society and ultimately their citizenship.

11. At a macro level, people felt that there needs to be a reorientation from secondary/acute care to primary/community care and this should be reflected in resource allocation and legislation regarding entitlements. Participants were impatient at the rate of progress towards a new primary care model in the community.

12. At a micro level, stakeholders wanted more emphasis on the promotion of health within community care with greater partnership between community care providers and health promotion departments.

13. The need for greater investment in social housing was emphasised at the regional seminars. Participants pointed to the apparent inability of health boards and local authorities to work together to solve housing problems for older people. They felt that suitable, barrier-free housing should be routinely available to older people.

14. A number of issues were identified at the seminars as important in the planning, development and operation of healthy ageing projects. These issues were appropriate needs assessment, adequate and sustained funding, social capital, partnership and information flows.

15. Elements of best practice identified during the seminars were consultation, empowerment, continuity, sustainability, information-sharing, outcomes, evaluation and equity.

8.1.3 Healthy Ageing Database

16. The most common category for healthy ageing projects is that of social environment with 45 per cent of all projects fitting into that category. The social environment category includes such elements as social interaction, public attitudes, retirement issues and income support.

17. The most popular setting for healthy ageing projects is day care/day centre at sixteen per cent followed by ARAs at fifteen per cent. Ten per cent of projects take place in an older person's own home, while ten per cent of projects occur in health board long-stay care.

18. Almost seventy per cent of projects developed from an initiative taken by the organisation running the project. This means that the majority of projects arise from the bottom-up, sometimes without much support from official sources.

19. Fifty per cent of projects claim that some form of needs assessment is conducted prior to undertaking the project.

20. Almost half of the projects in the Healthy Ageing Database have partners involved in the operation of the project.

21. Three quarters of participants in healthy ageing projects are female.

22. Projects are small in scale, with two thirds having less than fifty participants per week and a third having less than twenty.

23. Nearly twenty per cent of survey respondents identified inadequate funding as the main obstacle to the development of health ageing projects. This was followed by ageist attitudes (thirteen per cent), a lack of interest in healthy ageing among policy-makers (twelve per cent) and the absence of an integrated holistic approach to healthy ageing and well-being (twelve per cent).

24. Increased funding for social interaction and integration, and the promotion of better attitudes to old age and society were regarded as priority areas for the future by survey respondents, with sixteen and twelve per cent respectively of respondents highlighting these two areas. Mental health promotion also scored highly as did stroke prevention. Personal and creative development for older people was also seen as important.

25. Older people living alone were regarded as a priority group by many of the survey respondents, with nearly one in three replying that this category should receive additional funding, if such funding were to become available. Homeless older people, older people in deprived economic circumstances and rural older people were also thought of as deserving groups, with 35 per cent of respondents indicating that these groups should receive priority.

8.2 Implications for the Future With Reference to the Ottawa Charter

8.2.1 Building Healthy Public Policy

26. Ageism and inequality have been identified as a major issue affecting the opportunities open to older people to improve their own health and well-being. Combating ageism in public policy and the promotion of better attitudes to older people in society are required in order to maximise the impact of projects promoting healthy ageing. Challenging ageism requires a multi-pronged approach. Such an approach would influence the policy-making process through age-proofing of all Government policies that affect the health of Ireland's older people and through compulsory age-awareness training in the public service. The approach would also encompass changes in legislation to ensure older people are entitled to community-based social care services by right. Legislation that defines the compulsory retirement age is also in need of review. The use of upper age-limits in terms of access to goods and services, including insurance, should be addressed as recommended by the Equality Authority (2002). The media should also be used to combat ageism and a high profile national advertising campaign is recommended. Intergenerational solidarity should be fostered through the implementation of the NCAOP's *Young and Old* programme, an educational programme for primary schools that promotes intergenerational understanding and contact at an early age.

27. A designated and protected Healthy Ageing Fund should be established by the Department of Health and Children to encourage innovation and experimentation in respect of healthy ageing. There should be a competitive tendering process for large-scale projects and five annual large awards made under each of the headings of the Ottawa Charter. The annual fund should be in the region of €5 million and could also be used to support small-scale projects. Seed capital should be made available to smaller projects with a separate application for funding of this kind. The Fund could be administered by the NCAOP's Healthy Ageing Programme.

28. A culture of evaluation should be built into community- and service-based approaches to promoting healthy ageing, so that the benefits of preventive approaches and supportive environments can be measured. The development of evaluation processes and the dissemination of results will be required to convince policy-makers of the benefits of healthy ageing interventions in terms

of quality of life and in terms of value for money. The NCAOP should have a role in providing advice and support with the design of evaluations for agencies that need support in this area. Funding should be made available for evaluation and could also be administered by the Healthy Ageing Programme.

29. The recommendations of the Food Safety Authority on nutrition and older people (FSA, 2000) should be implemented. These recommendations take an intersectoral approach to improving nutrition on later life encompassing issues to be addressed by the retail and transport sectors, priorities for research, community dieticians, meals on wheels and the health services. The report indicates that interventions promoting healthier nutrition for older people are cost-effective (Larsson and Unosson, 1990). It is also important that older people be consistently targeted in integrated national strategies to reduce tobacco and alcohol-related harm.

8.2.2 Creating Supportive Environments

30. Every Government Department needs to build more commitment to keeping older people well and living in their own homes at national and regional level. The development of intersectoral groups to formulate policy promoting healthy ageing would be an important element of such an approach. This should ensure better integration of key Government Departments and regional agencies in projects and services for older people, and lead to holistic health and social care delivery. Service re-organisation should begin by putting older people at the centre of the decision-making process.

31. Housing plays an important role in keeping older people well, enabling them to live independently and maintain life-time social contacts and networks within their community. The housing stock of older people in Ireland needs to be improved, with greater provision of accessible and disability-adaptable housing. Sheltered accommodation should be provided by public/private/voluntary partnerships in each locality as part of a spectrum of transitional housing options between home and residential care. Older people and their representatives should be an important part of the partnership process in developing appropriate housing. Community care services should be linked to sheltered housing provision with the emphasis on health promotion and healthy ageing. Some older people in sheltered accommodation will eventually require nursing home care and careful planning should allow for seamless transition between community and residential care living for these people.

32. Transport is an important aspect of quality of life for older people. There are excellent examples in the Healthy Ageing Database of local projects which through innovative transport solutions have improved the lives of older people. There is a need to reduce the bureaucracy associated with the development of local social economy alternatives to public provision, particularly in rural areas. Free travel is a major contributor to healthy ageing and should be available *de facto* to all older people. A comprehensive transport needs assessment would answer the question of which groups of older people are currently discriminated against in respect of transport. A particular vulnerable group may be older people with disabilities who cannot access main services and may have no means of private transport.

33. Injuries are a major contributor to unhealthy ageing for older people. Many injuries happen at home including falls, burns and scalds. Some are caused by road traffic accidents, while falls in long-stay care also contribute to injuries and accidents. Physical activity can reduce the number of falls, so can designated projects based in the home and in long-stay care to reduce the number of falls. There are projects in the Healthy Ageing Database that demonstrate the benefits of dedicated falls prevention projects. Additional funding to support replication of these projects in both home and residential settings would make an important contribution to healthy ageing for older people. Annual testing of the continued ability to drive safely for all 'at risk' groups in society, based on competence and function, not age, may also be important.

8.2.3 Strengthening Community Action

34. Various attempts have been made to establish a more nationally representative network of older people. Notwithstanding a number of national organisations of older people and others working for older people, representation for older people in the socio-political structure remains under-developed relative to other European countries and especially to the USA. The relatively low level of public outcry at current services for older people and ageism in the healthcare system is evidence of the lack of success of existing representative groups in setting the political agenda for older people in this country. A major contribution to healthy ageing for older people would be direct and single representation of older people within the existing Social Partnership structure, as distinct from the current indirect representation as part of the Community Platform. For this to happen, there must be a new national federal structure of older people's groups to provide the unity, concentration and representativeness necessary for coordinated and successful lobbying. Competition between the various advocacy groups

representing older people serves only to dissipate the effectiveness of political lobbying. The development of advocacy mechanisms for older people at local and regional levels would be an important first step in building a more coherent representative structure for older people at national level.

35. There is a need for capacity-building for voluntary groups and ARAs at community level. The NCAOP's Healthy Ageing Programme should play a major role in this regard, as it could be a valuable resource to support voluntary groups in achieving best practice in the operation of healthy ageing projects. Capacity-building could take the form of supporting training workshops in planning, running and evaluating healthy ageing projects and supporting groups in an advisory capacity. ARAs have been acting as advocates for their more vulnerable members for a long while. They also provide a real opportunity for mutual self-help, which has an empowering effect on older people. They need more support, however, through seed funding for innovative healthy ageing projects and training in the area of participation and empowerment.

36. Older people should be placed at the centre of decision-making, both in the community and in residential care. The hypothetical case studies used to illustrate best practice in healthy ageing in this Report should form the basis of two pilot projects designed to explore the implications of providing greater autonomy and choice to older people in various settings.

8.2.4 Developing Personal Skills

37. Physical activity can benefit older people at all levels of ability by maintaining musculoskeletal and cardiovascular fitness. Maintaining and extending the Go for Life national programme should be an important component of future healthy ageing policy. More specific targets should be built into the Go for Life programme to ensure higher levels of coverage, particularly among those groups who are least likely to take exercise. More leisure and creative facilities, including outdoor public spaces, must also be provided so that they can be used by older people for physical and social activities. This would also help to remove negative stereotyping about an older person's ability to continue to be physically and socially active.

38. Social isolation, anxiety and depression are important contributory factors to loss of function in later life. Mental health promotion can play a key role in healthy ageing for older people (Cattan and White, 2000). Specific targeting of vulnerable older people through screening and subsequent social interaction

and networking projects can reduce isolation. Community activities, accessible transport and life-long learning courses can also help alleviate isolation and anxiety. Local initiatives, based on local knowledge, may be important in developing the social capital necessary to promote better mental health in local communities. For example, providing ongoing and appropriate support during bereavement can have a significant impact on healthy ageing.

39. The participation of older people in life-long learning and creative activities is also supportive of healthy ageing. It is encouraging to find many healthy ageing projects for older people in the area of the Arts and the public libraries are important hosts of many creative activities for older people. The exposure of older people to creative and artistic activities should become part of mainstream healthy ageing policy with increased funding for such activities coming from both the health boards and local authorities. People in residential care and in nursing homes should be given the opportunity to develop their creative potential. Where this has happened, outcomes and quality of life have improved for residents and staff.

8.2.5 Reorienting Health Services

40. Healthy ageing should form an integral part of the Primary Care Strategy. Pilot projects in the form of healthy ageing clinics should be supported in general practice. Specialist advice could be available to older people at these clinics, provided either by the GP or a specialist nurse. They could be used for screening and lifestyle advice, but could also be used to refer older people to specialist secondary care outpatients if appropriate.

41. The reorientation of treatment and health care from a medical model approach to a bio-psychosocial approach, involving older clients in their own care and tackling issues related to economic, social, psychological, communication, language and cultural barriers which currently impact on access to services.

42. Funding for community care services should be enhanced through the provision of person-centred community-based subventions for vulnerable older people. These subventions would allow older people more choice and facilitate the development of community-based services, some of which might be provided by an expanded social economy system.

43. Discharge policies are a key factor in determining how well an older person gets on after an episode of illness. Discharge policies could be greatly developed in terms of setting up a plan for the holistic well being of the older person after an acute episode of illness. While much of the current discussion on discharge policy is focused on the provision of nursing home beds for older people leaving hospitals, the role of housing should not be ignored in discharge policy. The development of comprehensive transitional housing for older people has been a necessity for some time and should be pursued as a matter of urgency by the Department of the Environment.

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Appendices

Appendix A

Healthy Ageing Database Project

There have been considerable developments in recent years in the broad field of healthy ageing projects for older people throughout Ireland. Consequently, there is a need to document existing healthy ageing activity in each health board with a view to sharing information and informing public policy in this area.

Dr Eamon O'Shea, NUI Galway, and Edel Murphy, iManage, Galway, have been jointly commissioned by the National Council on Ageing and Older People to undertake a comprehensive updating and remodelling of their Healthy Ageing Directory, leading ultimately to the development of best practice models for healthy ageing activities in Ireland.

A major part of our task is to document existing healthy ageing activity and to report on models of good practice across the country. We intend to gather information on healthy ageing projects through a regional seminar in each health board area, followed by a postal questionnaire administered to the directors of all known projects in each region. The information gathered through the questionnaire will be published on a database, which will be available on the National Council's web site.

The purpose of the regional seminar is threefold:

- to bring together representatives of healthy ageing projects from health boards, voluntary groups, community groups, local authorities and older people themselves
- to generate discussion that will inform national best-practice in the field of healthy ageing for older people
- to obtain a comprehensive list of contact persons and addresses for all healthy ageing projects and programmes in the region

A healthy ageing project means any innovative project designed to improve the quality of life and well-being of older people that is in addition to the normal services provided to the older people in the region. These projects can have their origins in the Health Board, community development groups, retirement groups, intergenerational groups etc.

We are also asking each person attending the seminar to provide a list of contacts for all know healthy ageing projects in their area, which we will use to generate a list for the postal questionnaire.

Appendix B

Regional Seminar

Healthy Ageing Project

National University of Ireland, Galway

Section A: Priority Setting

Section B: Planning and Development

Section C: Best Practice

Contact Address:
Dr Eamon O'Shea
Department of Economics
National University of Ireland Galway

A healthy ageing project means any innovative service or activity designed to improve the quality of life and well-being of older people that is ***in addition to*** the normal services provided for older people in the region.

Projects can have their origins in the health board, local authorities, community development groups, voluntary groups, retirement groups, intergenerational groups etc.

Section A: Current Priorities

A.1. Which areas in the broad field of healthy ageing CURRENTLY receive most attention and priority in terms of funding and other resources in the region?

Remember that healthy ageing projects and services can be provided by a wide range of organisations and agencies, including health boards, local authorities, voluntary organisations and community groups, so that you need to consider all potential areas.

To help you answer this question we have provided a list of potential healthy ageing areas in Appendix 1. The list is not meant to be exhaustive or to limit your thinking on this question, but it is meant to be indicative of the range of possibilities currently available.

Please rank CURRENT PRIORITIES from 1 to 3, if possible.

1.
2.
3.

Section A: Future Priorities

A.2. Which areas in the broad field of healthy ageing **SHOULD BE PRIORITIES IN THE FUTURE** in this region? In particular, if more resources were made available for healthy ageing projects which **three** areas should get these additional resources?

Once again, Appendix 1 is meant to help you think about potential priorities. However, there may be areas not listed in Appendix 1 that you consider should receive priority in the future.

Please rank **FUTURE PRIORITIES** from 1 to 3, if possible.

1.
2.
3.

Section B: Planning, Operation and Development

B.1. What are the major issues in respect of the planning, operation and development of healthy ageing projects and services in this region?

The range of issues that may come up here are many and varied. To help you think about planning, operation and development we have listed in Appendix 2 a number of potential issues that may be relevant. Once again, the list is not meant to be complete and there may be issues not on the list that you think should be included here.

Please rank, if possible from 1 to 3, the **major issues** with respect to the planning, operation and development of healthy ageing projects in this region.

1.
2.
3.

Section C: Best Practice in Relation to Healthy Ageing Projects and Services

C.1. What are the **three** most important elements of best practice in relation to healthy ageing projects and services?

Best practice might include some or all of the following: sustainability, continuity, partnership, consultation, empowerment, needs assessment, information-sharing, monitoring, evaluation, outcome-measurement and equity. There may also be other aspects of best practice not listed here that you consider important to mention.

1.

2.

3.

Appendix 1: Healthy Ageing Areas

- Prevention of heart disease ☐
- Stroke prevention ☐
- Cancer projects ☐
- Prevention of lung diseases/breathing disorders ☐
- Diabetes projects ☐
- Bone and joint projects (arthritis and osteoporosis) ☐
- Hearing and eyesight projects ☐
- Dental and oral projects ☐
- Foot disorder projects ☐
- Incontinence projects ☐
- Accident prevention (falls, fire, road) ☐
- Suicide prevention ☐
- Mental health promotion ☐
- Safety with medication ☐
- Stopping smoking ☐
- Sensible drinking ☐
- Nutrition and diet ☐
- Security and safety ☐
- Physical activity ☐
- Housing improvement ☐
- Transport improvement ☐
- Promotion of better attitudes to old age in society ☐
- Planning for retirement ☐
- Income and financial well-being ☐
- Social interaction and integration ☐
- Health promotion for carers ☐
- Personal and creative development ☐

Appendix 2: Potential issues in the planning, operation and development of healthy ageing projects

- [ ] The poor public image of health promotion
- [ ] The absence of needs-assessment data
- [ ] The difficulty of persuading older people of the benefits of healthy ageing activities
- [ ] The absence of partnership models for public, private and voluntary cooperation
- [ ] The absence of qualified people to design and lead projects
- [ ] The absence of integration and collaboration among health professionals
- [ ] Inadequate funding at national level for the development of projects
- [ ] Inadequate funding at regional level for the development of projects
- [ ] The absence of appropriate guidance on best practice in health promotion
- [ ] The absence of suitable training programmes for staff involved in projects
- [ ] The failure to allocate dedicated staff time to healthy ageing projects and services

Contacts for Healthy Ageing Questionnaire

As you are aware, the main objective of this research is to update and remodel the Healthy Ageing Directory of the National Council on Ageing and Older People.

We intend to gather information on healthy ageing projects through a postal questionnaire administered to the directors of all known projects in each region of the country. The information gathered through the questionnaire will be published on a database, which will be available on the National Council's web site.

Before we can administer the questionnaire we need to know the contact details of all healthy ageing projects in each region. This is where you can help. We need you to tell us the contact details of all projects known to you so that we can send a questionnaire to the directors of these projects.

Please send the contact details of healthy ageing projects known to you to the following address:
Dr Eamon O'Shea
Department of Economics
National University of Ireland Galway

Appendix C

Comments on the Seminar

We would welcome comments on the seminar under the following headings

1. Structure of the seminar

2. Feedback process

3. Content of the Questions

4. Relevance of the seminar for your work

5. General comments

Terms of Reference

Terms of Reference

The National Council on Ageing and Older People was established on 19th March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:

    a) measures to promote the health of older people;

    b) measures to promote the social inclusion of older people;

    c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;

    d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;

    e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;

    f) meeting the needs of the most vulnerable older people;

    g) means of encouraging positive attitudes to life after 65 years and the process of ageing;

    h) means of encouraging greater participation by older people;

    i) whatever action, based on research, is required to plan and develop services for older people.

2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

    a) undertaking research on the lifestyle and the needs of older people in Ireland;

    b) identifying and promoting models of good practice in the care of older people and service delivery to them;

    c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;

    d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.

3. To promote the health, welfare and autonomy of older people.

4. To promote a better understanding of ageing and older people in Ireland.

5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

Membership

Chairperson Cllr Éibhlin Byrne

Mr John Brady
Ms Kit Carolan
Mr Paul Cunningham
Mr John Grant
Ms Patricia Lane
Ms Martina Queally
Mr Bernard Thompson
Mr Noel Byrne
Mr Michael Dineen
Fr Peter Finnerty
Mr Eamon Kane
Mr Michael Murphy
Mr Pat O'Toole
Ms Pauline Clancy-Seymour
Mr Eddie Wade

Dr Davida De La Harpe
Mr Iarla Duffy
Mr Frank Goodwin
Dr Ruth Loane
Ms Sylvia Meehan
Mr Paddy O'Brien
Ms Mary O'Neill
Cllr Jim Cousins
Dr Ciaran Donegan
Mr James Flanagan
Dr Michael Loftus
Ms Mary Nally
Ms Rosemary Smith
Ms Martha Sullivan

Director Mr Bob Carroll

National Council on Ageing
and Older People

22 Clanwilliam Square
Grand Canal Quay
Dublin 2

Tel: 01 676 6484/5
email: info@ncaop.ie

An Chomhairle Náisiúnta
um Aosú agus Daoine Aosta

22 Cearnóg Chlann Liam
Cé na Mórchanálach
Baile Átha Cliath 2

Fax: 01 676 5754
website: www.ncaop.ie